Debriefing paper for the inspection of

HMP & YOI Chelmsford

by HM Inspectorate of Prisons

9–20 August 2021

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

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Healthy prison assessments

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

Outcomes for prisoners are reasonably good against this healthy prison test.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority there are no significant concerns. Procedures to safeguard outcomes are in place.

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

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

1. Leadership

Our judgements about leadership take a narrative form and do not result in a score.

- A previous programme of support from HMPPS known as Special Measures had been largely ineffective in improving outcomes at Chelmsford and none of our key concerns from our last inspection in 2018 had been fully achieved.
- In the autumn of 2020 HMPPS recognised the need to provide further support to improve outcomes through the introduction of a Prison Performance Support programme but this had experienced delays and one year later had barely begun.
- Significant changes within the leadership team at the prison had taken place over recent months including a new governor and deputy. They had clear ambitions to drive performance and were committed to improvements, but there was still a need for fuller engagement from the wider staff group in taking forward the priorities. It was clear to us that the governor and his team would need significant support in improving outcomes.
- The use of data was weak in many key functions and action to make improvements was lacking, even when data suggested it was needed.
- Leaders and staff paid insufficient attention to analysing, understanding and addressing poor outcomes, including those relating to safety. The key concerns found at our last inspection persisted.
- The dominant culture among staff was one of disillusionment and disengagement, issues that had been evident at Chelmsford for years. The culture was negative and damaging and failed to support or promote safety.
- There had been a clear lack of accountability and management oversight of practice at all levels, which enabled some poor performance and behaviour to go unchallenged. For example, many staff failed to respond to even basic requests from prisoners and too many were dismissive in their day-to-day dealings or evidenced only limited empathy for those in their care.
- Staff training had been neglected during the COVID-19 restrictions. Nearly a third of staff had been in post for less than two years and had not yet received adequate mentoring or support. There was no current training plan, but a new manager had taken up post recently and was seeking to rectify this.
- Partnership working between health care and the prison needed improving to ensure services were delivered as intended.
- Leaders had neglected Prisons and Probation Ombudsman (PPO) and HMI Prisons action plans which was poor given the areas of repeated concern including, for example, the high number of self-inflicted deaths over the last three years.
- Like other prisons, Chelmsford had been hit hard by the COVID-19 restrictions and a large-scale outbreak in the first few months of 2021 made it difficult for the prison to deliver even the very basic regime for about two months. This outbreak was managed well but since then the pace of

recovery from the restrictions had been far too slow. For example, most prisoners were still locked in cell for almost 23 hours a day.

2. Safety

Outcomes for prisoners against this healthy prison test remained poor.

Early days in custody

- Chelmsford remained a busy local prison receiving around 48 new arrivals each week.
- Despite some redecorating, the reception area was in need of further improvement. Holding rooms were stark and some toilets were unscreened.
- Prisoners were interviewed in private both during the reception process and when located on the first night centre.
- The regime on the first night centre was poor. Some prisoners spent too long there before being moved to another wing. They waited too long to get their basic needs met.
- Cells approved for occupation were often poorly prepared and prisoners spent too long locked in their cells.
- The full induction programme had been suspended at the start of the pandemic and had not restarted, which was a gap.

Managing behaviour

Encouraging positive behaviour

- In our survey, 27% of prisoners said that they currently felt unsafe which remained similar to our 2018 finding.
- Violence levels remained among the highest of all local prisons since 2018.
- Almost half of the prisoners in our survey said that they had been victimised by staff and those with disabilities and mental health problems were significantly more negative.
- Leaders placed too much reliance on the safer custody team to address violence, but the team were not provided with consistent resources to deliver these priorities and there was insufficient support for this work from staff and leaders.
- The challenge, support and intervention plan (CSIP) process was not used effectively. There was insufficient challenge of the behaviour of perpetrators of violence and support for victims was poor.
- The use of data was limited and did not inform the violence reduction strategy. There was no associated plan to drive and monitor actions to reduce violence and make the prison safer.
- There was no strategy to use incentives to improve the culture and the regime. The use of basic privileges had been reintroduced to challenge poor behaviour but was not being applied consistently.

Adjudications

- The number of adjudications over the previous 12 months was similar to our last inspection, although we found that some charges could have been dealt with by more informal responses.
- Poor quality report writing meant that some charges had had to be abandoned, although it was more positive that work had taken place to reduce the number of adjourned charges.

Use of force

- The number of times use of force had been used had reduced slightly since our last inspection but remained higher than many similar prisons.
- Most incidents of force were unplanned, and they often involved younger prisoners.
- In the cases we reviewed, we were satisfied that incidents were proportionate and there was evidence of de-escalation. However, staff did not routinely activate body-worn video cameras in response to unplanned incidents.
- A monthly report contained a useful range of data, but despite analysis, actions were not identified to further reduce the use of force.

Segregation

- The segregation unit was reasonably clean, but some cells were damp, and we were told about poor drainage issues.
- The daily regime was poor and more could have been done to encourage those who failed to engage.
- There had been good focus on the reintegration of a few very complex prisoners into the general population.
- Despite a useful range of available data for all aspects of disciplinary procedures (segregation, force and adjudications), there was no systematic analysis to drive improvements in practice and promote positive outcomes.

Security

- Security arrangements were generally proportionate and aligned to the risks. However, some procedures were disproportionate, such as the routine use of handcuffs for prisoners being escorted to hospital and strip-searching in reception.
- Awareness of key threats was good, but there was little analysis of data or identification of actions to ensure progress. Intelligence reports were not analysed quickly enough so there was a large backlog and it was not always clear what action had been taken as a result.
- The supply of illicit drugs and other items remained a clear threat. Some positive steps had been taken to try to manage this, but we were surprised to find that the body scanner was often not used, and drug testing was yet to recommence.

- Leaders had worked effectively with the police when staff corruption was suspected, and this had yielded some positive results.

Safeguarding

Suicide and self-harm prevention

- Despite some serious failings identified by the PPO and others, the key concerns and recommendations from our last inspection had not been achieved.
- There had been eight self-inflicted deaths and four non-natural deaths since 2018.
- There had also been a large increase in the number of self-harm incidents since 2018, reflecting an increase across four successive inspections.
- The PPO action plan was out of date and implementation of some of the recommendations had been too slow.
- During our night visit we observed serious flaws in safety practice.
- Staff lacked confidence in using the new ACCT document and felt they had received too little training. We found many weaknesses in its completion. Prisoners we spoke to were mixed in their views about support provided while on an ACCT.
- The strategic approach to self-harm was limited and there had been no detailed analysis of data to fully understand the causes and drivers.
- There were too few Listeners for the population and access to them was poor, with only 34% of prisoners in our survey reporting it was easy to speak to a Listener if they wanted to.

Protection of adults at risk

- The adult safeguarding policy was brief and links with the local safeguarding adults board had lapsed.
- Most staff we spoke to were unfamiliar with safeguarding procedures and associated procedures, which increased the risk of needs being missed.

3. Respect

Outcomes for prisoners against this healthy prison test remained not sufficiently good.

Staff-prisoner relationships

- In our survey, about two-thirds of prisoners said that most staff treated them with respect and that there were staff they could turn to if they had a problem; both of these were significantly more negative than at our last inspection. Some groups of prisoners, including younger adults were even more negative in their views than others.
- Many prisoners we spoke to could name good staff and we observed some friendly and supportive interactions. However, the most common theme reported by prisoners was of staff not responding to basic requests, being dismissive and not showing care or compassion. This led to high levels of frustration and prison leaders suggested this was linked to an increase in assaults on staff. This negative and damaging staff culture undermined the focus on rehabilitation and had been allowed to go unchallenged for far too long.
- Other factors such as poor time out of cell and the high use of force presented further barriers to effective staff-prisoner relationships.
- As in our last inspection, there were plans to provide additional support and training for staff, but none of this work was yet in place. The lack of staff training in mental health and trauma were significant gaps.
- The key worker scheme was not working as intended by the Offender Management in Custody (OMiC) model and plans to restore it were not ambitious.

Daily life

Living conditions

- The older part of the prison was cramped and remained significantly overcrowded. The newer wings were better laid out, brighter and more open.
- Standards of cleanliness on most wings had improved since our last inspection. However, many cells across the site were very grubby and in poor repair. We saw many cells with graffiti and inadequate furniture. There was a shortage of some key amenities, including pillows, decent mattresses, and kettles.
- Only 55% of prisoners in our survey said they normally had enough clean, suitable clothes for the week. Only 50% said they had clean sheets every week. Wing laundry facilities were inadequate and weekly kit change did not always happen.

- Despite work to control the issue, there was still a significant problem with rats, including on wings and in food servery areas.
- There was inadequate oversight of staff response times to emergency cell bells. In logs we looked at, there were delays of up to 39 minutes.
- Staff appeared to have become inured to the poor conditions and some inexperienced staff did not have the benefit of comparing conditions at Chelmsford to conditions found in other prisons.

Residential services

- In our survey, only 19% of prisoners said the food was very or quite good and only 16% reported they had enough to eat at mealtimes. We also saw lunch being served at cell doors which was unnecessary.
- The main kitchen was unkempt and grubby. Some equipment was in poor repair and poor drainage left water pooling in cooking areas.
- Most prisoners told us the prison shop sold what they needed, although new arrivals still had to wait almost two weeks for their first order.

Prisoner consultation, applications and redress

- Prisoners had not had chance to attend the prison council since the start of the pandemic.
- Application forms were widely available on wings, but prisoners' confidence in the system was low and the prison had no quality assurance process in place.
- The number of complaints was high, and the responses we reviewed did not always address the problem raised.

Equality, diversity and faith

Strategic management

- Strategic oversight of equalities work had improved since the last inspection. However, some weaknesses remained, and provision had been further adversely impacted by COVID-19 restrictions.
- There was now a monthly meeting to oversee equality work, and good partnership working with Ipswich and Suffolk Commission for Race Equality (ISCRE). The meeting was informed by some particularly good consultation with black and minority ethnic prisoners. It was much less focused on the needs of prisoners in other protected groups.
- A wide range of equality data was collated but analysis of data was generally weak. There was insufficient discussion and action on some areas of disproportion, such as the use of force against black and minority ethnic and younger prisoners.
- The quality of most discrimination incident reporting form (DIRF) investigations and responses was good.
- On the whole, prisoners in protected groups reported similar treatment and conditions in their responses to most questions in our survey.

- Some reasonable efforts had been made to provide translated material, but professional telephone interpretation was not always used when required.
- There had been insufficient attention to the needs of prisoners with disabilities and not enough adjustments had been made to meet their needs. Arrangements for their evacuation were inadequate. Informal 'buddy' arrangements were not supervised.
- Although the Youth Council continued to meet throughout much of 2020, it was currently suspended. The younger persons strategy was predicated on the provision of a good regime and had not been adjusted to account for COVID-19 restrictions.
- In our survey, fewer prisoners than in our last inspection said their religious beliefs were respected. Religious classes and communal worship remained suspended, although chaplains had continued to see prisoners face-to-face, and pastoral support remained strong. The multi-faith room was run down.

Health, well-being and social care

- Some aspects of health care had improved but significant staffing issues within the pharmacy and mental health teams had a negative impact on service delivery.
- We found too many examples of patients missing doses of their medication or waiting too long for medication to arrive, which was poor.
- There remained some weaknesses in partnership working between the prison and health care services, with longstanding issues such as inconsistent officer support to effectively manage medicine administration and the cancellation of external hospital appointments happening too frequently.
- Effective communication between key stakeholders was evident in the management of COVID-19. The rollout of the COVID-19 vaccination programme had been progressing well but had been delayed due to an error in administration.
- The management of long-term health conditions and complex needs had generally improved since the last inspection, with evidence-based care plans and patients receiving regular reviews.
- All prisoners aged over 50 were screened by health care staff to assess their ability to complete daily living activities and were offered additional support, which was notable positive practice.
- Partnership working between the prison and Essex County Council in relation to social care needed improvement. Despite this, social care outcomes for prisoners were generally good.
- Officers on the enhanced care unit knew the prisoners well and were caring. Most of the prisoners had mental health needs but the unit lacked an overall therapeutic approach and its function was unclear.
- Forward Trust substance misuse clinical and psychosocial services were very good.
- The prison was one of two national pilot sites for the prescribing of Buvidal (buprenorphine by depot injection) in prisons, which was innovative.
- The mental health team was mostly made up of agency nurses which meant that continuity of service may have been compromised. They provided good

support on a needs basis rather than having individual caseloads to cover the staffing deficits within the team.

- The Improving Access to Psychological Therapies (IAPT) service was providing good support and had been commissioned to make contact with a specific cohort of prisoners to reduce the risks of suicide, which was a promising initiative.
- Patients requiring transfer to secure mental health facilities continued to wait too long for a place.
- There was a long waiting list for the dentist. The provision of AGP treatment was delayed because officers didn't have the correct PPE to enter the room in an emergency.

4. Purposeful activity

Outcomes for prisoners against this healthy prison test remained poor.

Time out of cell

- Prisoners were not sure when they would be unlocked as the core day was not published and there were inconsistencies in the account different staff gave about the daily regime.
- Only 15% of prisoners were in full-time employment. They could spend up to seven hours out of their cell.
- Over 16 months after the pandemic began, almost half the population was unemployed. They were locked in the cells for almost 23 hours a day, which placed an inevitable toll on their well-being.
- Our roll checks found 50% of prisoners locked in cells during the working day.
- Although regular, exercise periods were still too short.
- There was little creative use of peer workers to promote constructive activity.

Library and PE

- The library had been closed since the beginning of the pandemic and was only reopened during our inspection. The remote library service was not well promoted by prison staff and its use had been limited.
- COVID-19 had led to the closure of the gym and it didn't reopen until June 2021, which was later than many other prisons.
- There were credible plans for the reintroduction of accredited learning through the gym and links to the community such as the FA Twinning project.

Education, skills and work activities

- Leaders and managers had worked closely with the education provider to ensure that prisoners had access to in-cell education through a variety of learning packs during the national restrictions.
- Leaders and managers had successfully put in place their plans to bring back the full curriculum in education, skills and work. This allowed small groups of prisoners to return to face-to-face teaching and instruction in almost all subject areas.
- Leaders recognised that they did not maximise the number of prisoners accessing the available activity places and more places were needed to meet the needs of the population. Attendance was often too low, and prisoners' punctuality was not always good.
- Since the previous inspection and moving into stage 3 of the recovery programme, leaders had introduced new courses. Prisoners had completed new courses in food hygiene and had recently started a course in barbering.

- The courses and work available for vulnerable prisoners and those in the drug rehabilitation unit were limited.
- Tutors and instructors provided good support to prisoners to develop their skills and gain new knowledge. Prisoners understood how they could use these newly acquired skills outside of the prison.
- Most prisoners enjoyed their learning. In-cell learning packs helped them to develop their knowledge in a logical way.
- Tutors marked prisoners' work frequently and gave prisoners useful feedback about how well they completed assessments. However, in a few instances tutors did not give prisoners precise feedback on how they could improve their work, such as in grammar and punctuation.
- The information, advice and guidance prisoners received at their induction was generally effective. However, the ongoing advice and guidance was not planned and developed well enough to help prisoners move on to their chosen next steps.
- Most prisoners felt well supported by staff. Tutors supported those prisoners identified as needing extra help, such as those with dyslexia, appropriately. However, prisoners with more complex needs, such as autism, did not benefit from clear, individualised support plans to help them.

5. Rehabilitation and release planning

Outcomes for prisoners against this healthy prison test were now not sufficiently good.

Children and families and contact with the outside world

- In our survey, only 18% of prisoners said staff had encouraged them to keep in touch with their family and friends, which was significantly lower than in 2018. However, the prison had, very recently, developed a positive strategy and action plan to promote this.
- At the time of the inspection face-to-face social visits were not available at the weekend, which was a significant gap.
- Family days and parenting courses had stopped at the start of the pandemic and there were no clear plans to reintroduce them.
- All visitors we spoke with said they had been treated with respect during the visit, but all also said they had experienced significant delays in getting through to the booking office by telephone.
- In our survey, almost all prisoners said they could use the phone every day, but we found some prisoners who did not have a phone in cell and one prisoner had not had one for a month.

Reducing risk, rehabilitation and progression

- Management of reducing reoffending work had been neglected last year but it had recently improved and looked promising, with a good needs analysis, strategy and action plan to drive forward improvements.
- Resettlement agencies had recently returned to working on site but were still not always seeing prisoners face to face.
- About 40% of the population were eligible for offender management support. As a result, offender management unit caseloads were relatively small. However, uniformed prison offender managers (POMs) often lost most of their time through cross deployment to other duties within the prison.
- Most eligible prisoners had an initial OASys and we found that initial resettlement plans were being completed on time. However, in our survey only 14% of prisoners knew they had a plan.
- Contact between prisoners and POMs varied greatly. In addition, the key worker scheme was not operating.
- Home detention curfew (HDC) was managed reasonably well within the prison but almost a third of prisoners were released late, often for reasons outside the control of the prison.

Public protection

- Public protection arrangements were not robust. For example, the inter-departmental risk management team (IDRMT) had not been functioning

since the start of the pandemic, although there was evidence of reasonable risk management planning by individual POMs.
- The number of prisoners under mail and phone monitoring to protect the public was not excessive. However, there was a backlog of phone calls waiting to be monitored and we were concerned that requirement to monitor could be removed without the evidence to do so.

Categorisation and transfers

- Initial categorisation and reviews were timely, and most prisoners were promptly moved to another prison following sentencing.
- However, there were some difficulties in transferring category B prisoners and sometimes those convicted of sexual offences.

Interventions

- In 2018 we saw an innovative range of interventions to address offending behaviour, so it was disappointing that these had ended.
- The psychology department supported some prisoners on a one-to-one basis but POMs were not trained to deliver bespoke interventions for those convicted of sexual offending or domestic violence.

Release planning

- In our survey, only 43% of prisoners said someone was helping them to prepare for release.
- Too many prisoners were released without a suitable or sustainable address to go to and monitoring of this issue was poor.
- Despite a high level of need, support for finance, benefit and debt problems was weak.
- The positive resettlement 'drop-in centre' six weeks prior to release had not yet fully reopened.
- Resettlement planning in all the cases we reviewed was reasonably good, but there was little basic support on the day of release.