Report on an unannounced inspection of

HMP Coldingley

by HM Chief Inspector of Prisons

6 and 10–14 January 2022

Contents

Introduction

The prisoners at Coldingley, a category C training prison in Surrey, were spending up to seven hours a day unlocked; this was in contrast with other jails we had recently inspected, where prisoners were lucky if they got out of their cells for more than a couple of hours. Our visit came as the prison was recovering from a recent COVID-19 outbreak, but leaders had kept the regime open while successfully managing the risk for the 431 prisoners who were being held there.

Levels of violence at Coldingley were around average for the category C estate and the prison generally had a calm and friendly atmosphere. A consistent regime was presided over by a strong cadre of dedicated and skilled prison officers, though the oversight of support for prisoners at risk of suicide or self-harm needed improvement. At times it seemed to inspectors that the atmosphere was a little too laid back and there a tolerance of some low-level behaviour that should have been addressed. It was disappointing to see from our survey how readily drugs were available in the prison and there needed to be a concerted effort from leaders to reduce the supply.

Since I came into post in November 2020, I have rarely visited a jail about which prisoners spoke so positively. This was particularly impressive because the fabric of the prison in the older parts was poor, with cold, dark cells and shabby communal areas. A night sanitation system remained in place on A–D wings and waits to use the lavatories were so long that prisoners often had to revert to using a bucket in their cell and were unable to wash their hands. Inspectors were encouraged to hear that a much needed, extensive refurbishment plan was in place.

Considering the time prisoners were unlocked, it was disappointing that the provision of education was so poor, with Ofsted colleagues awarding it their lowest rating. This was a huge missed opportunity to get prisoners onto productive leaning pathways that would help them to resettle when released. There was also a lack of work opportunities available for prisoners, which meant that some did not have enough to do during the day and were not able to get used to normal working habits. Prisoners were not being sufficiently incentivised or challenged to go to work or attend education and during this inspection, we found too many either in their cells watching daytime television or socialising on the wings during working hours.

The effective and thoughtful governor knew his prison well and had well-developed plans in place to make improvements. As the disruption of the pandemic receded, he and his team had the opportunity to build on the excellent staff-prisoner relationships and to focus on making sure that all prisoners spend their time productively, either working or in education. There was also scope for building relationships with local employers, in a part of the country with a buoyant jobs market, to offer release on temporary licence for those prisoners who met the threshold. This would further prepare them for working life and incentivise good behaviour and attendance among the rest of the population.

Coldingley was a well-run and decent prison, but with renovation of the buildings, the development of a comprehensive, challenging work and education offer, and the reduction in the supply of drugs there was scope for further improvements. The governor and his team should be ambitious in aiming to make this prison a model for other category C establishments in the country.

Charlie Taylor
HM Chief Inspector of Prisons
February 2022

About HMP Coldingley

Task of the prison/establishment
Coldingley is a category C training and resettlement prison for adult males, holding mostly long-term, including life-sentenced, prisoners.

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 431
Baseline certified normal capacity: 493
In-use certified normal capacity: 483
Operational capacity: 433

Population of the prison
- 418 new prisoners received in 2021.
- 56 foreign national prisoners.
- 43% of prisoners from black and minority ethnic backgrounds.
- Around 11 prisoners released into the community each month.
- 170 prisoners had been transferred to open conditions in the last 12 months.
- 134 prisoners receiving support for substance misuse.
- Up to 10 prisoners referred for mental health assessment each month.

Prison status (public or private) and key providers
Public

Physical health provider: Central and North West London NHS Foundation Trust
Mental health provider: Central and North West London NHS Foundation Trust
Substance misuse treatment provider: Forward Trust
Prison education framework provider: Weston College
Escort contractors: Serco; GEOAmey

Prison group
Kent, Surrey and Sussex

Brief history
Coldingley opened in 1969 as a category B industrial training prison. In 1993, it became a category C prison. E wing was opened in 2009 and an additional temporary unit, G wing, in 2020.

Short description of residential units
A–D wings 93 prisoners each, mostly in single cells; none have internal sanitation, except for three double cells on each landing/wing.
E wing 115 single cells and eight double cells with internal sanitation, including a shower.
G wing 60 prisoners; all pods have internal sanitation, including a shower.

Name of governor and date in post
Niall Bryant, August 2020

Leadership changes since the last inspection
Jo Sims to August 2020

Prison Group Director
Susan Howard

Independent Monitoring Board chair
Heather Cook

Date of last inspection
20 February–3 March 2017

Section 1 Summary of key findings

1.1 We last inspected HMP Coldingley in 2017 and made 39 recommendations, three of which were about areas of key concern. The prison fully accepted 30 of the recommendations and partially (or subject to resources) accepted six. It rejected three of the recommendations.

1.2 Section 8 contains a full list of recommendations made at the last full inspection and the progress against them.

Progress on key concerns and recommendations from the full inspection

1.3 Our last inspection of HMP Coldingley took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for prisoners at the time. Although we recognise that the challenges of keeping prisoners safe during COVID-19 will have changed the focus for many prison leaders, we believe that it is important to report on progress in areas of key concern to help leaders to continue to drive improvement.

1.4 At our last full inspection, we made one recommendation about key concerns in the area of safety. At this inspection we found this recommendation had not been achieved.

1.5 We made two recommendations about key concerns in the area of respect. At this inspection we found that both of those recommendations had not been achieved.

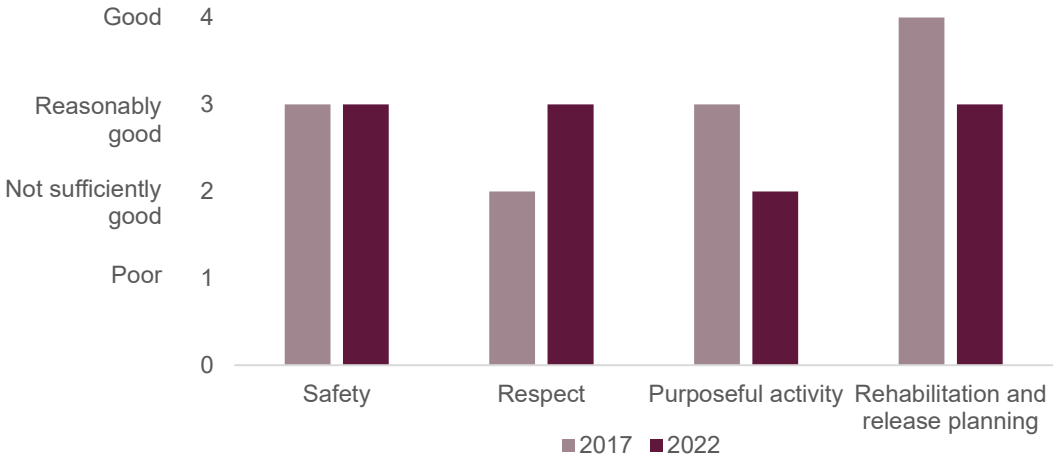
Outcomes for prisoners

1.6 We assess outcomes for prisoners against four healthy prison tests (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.7 At this inspection of HMP Coldingley, we found that outcomes for prisoners had stayed the same in one healthy prison area, improved in one and declined in two.

1.8 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account the prison's recovery from COVID-19 as well as the 'regime stage' at which the prison was operating, as outlined in the HM Prison and Probation (HMPPS) National Framework for prison regimes and services.

Figure 1: HMP Coldingley healthy prison outcomes 2017 and 2022



Safety

At the last inspection of Coldingley in 2017 we found that outcomes for prisoners were reasonably good against this healthy prison test.

At this inspection we found that outcomes for prisoners remained reasonably good.

1.9 New arrivals experienced generally good reception procedures with several opportunities for staff to identify any vulnerability. First night cells were in poor condition and some contained offensive graffiti. Induction was comprehensive and conducted in person.

1.10 Most prisoners were unlocked, and the wings remained calm and settled during our inspection. Prisoner-on-prisoner assaults were 20% lower than at the previous inspection, and much lower than at similar prisons. Drug-related debt remained the leading cause of violence; the most serious perpetrators being subject to adjudication and monitored through challenge, support and intervention plans (see Glossary). There was good support for victims and those identified as potentially at risk from violence. Sufficient time out of cell, positive staff-prisoner relationships, extensive work opportunities and the ability to progress to better accommodation on E and G wings encouraged prisoners to behave well. However, the prison's response, tackling some low-level poor behaviour was not robust enough.

1.11 The use of force was low compared with similar prisons. Very few incidents led to full restraint and there was evidence of good de-escalation. The average length of stays in the segregation unit was relatively short. Staff and prisoner relationships in the unit were positive, but the regime was poor and reintegration planning was inadequate.

1.12 Security arrangements were broadly proportionate for a category C prison. The security team had effective measures to manage the entry of illicit mobile phones and weapons, but the response to drugs was less robust. There was no mandatory or suspicion drug testing, and

inadequate CCTV coverage and supervision on residential wings. The prison lacked a coordinated drug supply reduction plan to improve outcomes in this area.

1.13 Levels of self-harm were lower than in most comparable prisons. Investigations into incidents of serious self-harm were good, as were complex case reviews that sought to support prisoners with the highest levels of risk. There was an effective and well-supported Listener scheme (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners). However, levels of self-harm had increased since our last visit and there was no coordinated plan to address this. The quality of assessment, care in custody and teamwork (ACCT) casework documentation was variable and quality assurance processes were yet to address identified issues effectively.

Respect

At the last inspection of Coldingley in 2017 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection we found that outcomes for prisoners were now reasonably good.

1.14 In our survey, 82% of prisoners reported that staff treated them with respect and had someone to turn to, which was higher than at similar prisons. We observed good relationships between staff and prisoners, and most staff had good knowledge of those in their care. However, staff did not always challenge low-level poor behaviour. The quality and frequency of key work (see Glossary) was inconsistent.

1.15 Despite some efforts to keep wings clean, accommodation on the older units remained poor. Prisoners did not have a toilet or sink in their cells and sometimes waited for hours before being unlocked to use communal facilities. Many prisoners reported continued issues with inadequate heating, compounded by broken windows in cells. Living accommodation on E and G wings was better; cells were more spacious, well equipped, and benefited from in-cell toilets and showers.

1.16 In our survey, prisoners were more positive about the quantity and quality of the food than at similar prisons, and they could access some self-catering facilities.

1.17 Prisoner council meetings were chaired by the governor, but it was not clear if consultation led to positive change. There were weaknesses in the prisoner complaints and application processes.

1.18 In our survey, prisoners with protected characteristics reported similar outcomes to others and it was clear that some staff had provided informal support to meet individual needs. However, the promotion of equality had not been prioritised by leaders and there were weaknesses in the identification and support for prisoners with protected characteristics. The provision and facilities for corporate

worship were very good and the chaplaincy provided valuable support to prisoners.

1.19 Leadership and strategic oversight of health care were good and made sure there was effective monitoring of the provision. A dedicated primary care team delivered a wide range of health services, although waiting times for podiatry and optometry were too long. Early days mental health provision exemplified good practice, and substance misuse services were safe and effective. Gaps in the provision of psychological therapy had resulted in some unmet patient need. There was a reasonable pharmacy service and dental services were sufficient.

Purposeful activity

At the last inspection of Coldingley in 2017 we found that outcomes for prisoners were reasonably good against this healthy prison test.

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

1.20 Prisoners at Coldingley had more time out of cell than at most other closed prisons. Almost all prisoners were unlocked for around seven hours a day and those on G wing were unlocked all day. They could visit the library and go to the gym twice a week.

1.21 Despite sufficient time out of cell, too few prisoners were engaged in education, skills or work activities and too many were unemployed. Prisoners in education made slow progress in developing new knowledge and skills. Very few of those with additional needs received the support they needed to engage in learning effectively. However, prisoners on distance learning programmes benefited from dedicated tutor support in education, which enabled them to make good progress in their studies.

1.22 There were insufficient accredited programmes available to prisoners through work roles and workshops. The range of provision was too narrow in employer-led workshops, and the work prisoners completed was mundane and lacked challenge. Too few prison instructors were qualified in teaching or training.

1.23 Prisoners in education and work activities behaved well and had a good rapport with staff, and those engaged in vocational workshops worked effectively and productively.

1.24 Allocation to education, skills and work was not linked to prisoners' aspirations or needs, and they did not receive advice and guidance about future employment plans. It was too early to see the impact of the recently improved induction, and advice and guidance service.

1.25 There were sufficient activity spaces for the population and leaders made sure that the curriculum was well informed by local labour market

intelligence and prisoner needs. They had identified accurate strengths and areas for development for education and vocational training. However, they had not considered the quality of teaching and curriculum content and had done too little to address known weaknesses. There was insufficient oversight of the quality of activities outside of education. Professional development for teachers was too focused on operational matters and did not help them improve their teaching and assessment practices.

1.26 Leaders did not make sure that there was sufficient capacity in education to help the high proportion of prisoners with low levels of literacy and numeracy to improve their skills in these subjects. The prisoner pay policy did not provide incentives to take part in education and they could earn more from most other roles in the prison.

Rehabilitation and release planning

At the last inspection of Coldingley in 2017 we found that outcomes for prisoners were good against this healthy prison test.

At this inspection we found that outcomes for prisoners were now reasonably good.

1.27 Social visits had resumed in May 2021 with sensible infection control protocols in place. Video call visits facilities on each unit allowed easy and unlimited access for prisoners. Family days had recently recommenced and were popular.

1.28 Reducing reoffending work lacked clear direction and there was insufficient focus on sentence progression. There was no credible action plan or evidence that data were used to monitor and improve outcomes. Prison offender manager (POM) contact with prisoners was reasonable with more frequent contact in high-risk cases. POM activity was task-driven and reactive, but overall was of good quality. Most of the sentence plans and risk management plans we reviewed were reasonably good.

1.29 The inter-departmental risk management team had an appropriate focus on managing prisoner risk in preparation for their release. The quality of reports prepared for multi-agency public protection arrangements (MAPPA) meetings was good, as was information-sharing with community offender managers.

1.30 In the previous 12 months, 170 prisoners had been moved to open conditions. There were some delays to recategorisation due to out-of-date offender assessment system (OASys) reports and because prisoners had not completed offending behaviour work. Coldingley had stopped delivering all offending behaviour programmes and in the previous 12 months only one prisoner had been transferred to complete a programme elsewhere. Some prisoners had not sufficiently reduced their risk of harm or reoffending due to the lack of accredited offender behaviour work.

1.31 There were about 10 releases into the community each month, about half of whom were high risk and therefore released to approved premises. The prison was unable to provide data on the number of prisoners released without a suitable address. Every release was considered at the monthly resettlement meeting to make sure that all relevant action had been taken to meet prisoners' needs before they left.

Key concerns and recommendations

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

1.33 During this inspection we identified some areas of key concern and have made a small number of recommendations for the prison to address those concerns.

1.34 Key concern: In our survey, 38% of prisoners said drugs were easy to get hold of at the prison and most safety issues related to debt were associated with the use of illicit substances. Drug testing and aspects of searching were inadequate. The prison lacked an effective multidisciplinary strategy to reduce the supply of drugs and manage associated problems.

Recommendation: Leaders should develop a coordinated prison-wide strategy to detect and reduce the supply of illegal drugs and associated debt, bullying and violence.
(To the governor)

1.35 Key concern: The quality of some assessment, care in custody and teamwork (ACCT) casework management documents for at-risk prisoners was poor. Actions agreed at case reviews were not always identified on care plans, which left staff ill equipped to follow them through. The quality assurance system and subsequent action plan had not addressed the problem.

Recommendation: A robust quality assurance system should make sure that actions agreed at assessment, care in custody and teamwork (ACCT) reviews are clearly recorded on care plans and then completed by staff to help prisoners through their period of crisis.
(To the governor)

1.36 Key concern: Over half the prisoners lived on the older wings in poor conditions. The outdated sanitation system meant there were no toilets or running water in cells. Prisoners faced long waits to use the communal toilets or were forced to use buckets in their cells with no facilities to wash their hands. Cells were cramped, dingy and cold, which was compounded by broken and moulding windows.

Recommendation: All prisoners should live in in suitable accommodation with reliable heating, a toilet and hand washing facilities.
(To the governor)

1.37 Key concern: Work to ensure equality at the prison had not been prioritised during the pandemic. Leaders did not monitor disproportionality, the equality action plan had been closed and consultation with prisoners with protected characteristics was very limited.

Recommendation: There should be effective consultation and monitoring to make sure that the needs of prisoners with protected characteristics are identified and met, and that disproportionate outcomes are addressed.
(To the governor)

1.38 Key concern: Psychological therapy provision did not meet patient need, with staff shortages resulting in approximately 40 waiting for their treatment to start, some for many months.

Recommendation: Patients diagnosed with a need for psychological therapy should be treated promptly.
(To the governor)

1.39 Key concern: Leaders and managers had not considered the quality of teaching and assessment, the appropriateness of the content of learning programmes or how effectively education and training courses were designed. No effective action had been taken to make sure that the quality of education, skills and work improved, and too many prisoners were not successful in their learning.

Recommendation: Leaders should identify accurate areas for improvement in teaching and assessment practices, and in curriculum design and content. They should also identify and implement actions to make sure that teachers and instructors improve their skills in teaching, and enable prisoners to build on, and make progress in, developing their skills and knowledge.
(To the governor)

1.40 Key concern: A high proportion of prisoners chose not to attend their allocated education, skills or work activity, and too many remained unemployed and not engaged in any purposeful activity.

Recommendation: Leaders and managers should ascertain the reasons why prisoners do not wish to engage in education and work, and take effective action to improve attendance and the proportion of prisoners allocated to appropriate activities. Prison staff should consistently promote the benefits of education to prisoners in their rehabilitation and future employability.
(To the governor)

1.41 Key concern: The prison induction did not provide prisoners with useful information about their options for activities at the prison and to make informed and appropriate choices. Prisoners did not receive impartial careers advice and guidance to establish their aspirations or help make suitable choices about future employment.

Recommendation: Information about prisoners' aspirations and long-term employment goals should be used to inform allocations to education, skills and work activities, and they should receive impartial advice and guidance that promotes career development.
(To the governor)

1.42 Key concern: There was no effective oversight of education, skills and work and the quality of prison-led activities was not monitored. Most prisoners in prison-led workshops were not challenged by their work roles and instructors did not help them to learn new skills. The progress that prisoners made in these areas was not recognised or recorded effectively, and too few prison-led activities resulted in accreditation.

Recommendation: The quality of prison-led activities should be monitored. Prisoners should be sufficiently challenged in all workshops, instructors should recognise and record the progress they make, and the number of accredited programmes in prison-led activities and prisoners who achieve these should be increased.
(To the governor).

1.43 Key concern: The prison lacked an adequate needs analysis to clearly identify the resettlement needs of the population. The reducing reoffending strategy and associated meeting did not identify and drive actions to make sure that support was available across all pathways. There was no evidence that data were used to monitor and improve outcomes.

Recommendation: Leaders should identify and understand the resettlement needs of the population and make sure that interventions and services are provided to meet those needs.
(To the governor)

1.44 Key concern: There was insufficient focus on, and opportunities for, sentence progression by prisoners. Coldingley had stopped delivering accredited offending behaviour programmes and prisoners were not transferred to complete these elsewhere. There was little one-to-one offending behaviour work with prisoners, and sentence plans often failed to identify specific offending behaviour targets. Some prisoners had not reduced their risk of harm or reoffending sufficiently before release.

Recommendation: Prisoners' offending behaviour needs should be identified and met to reduce their risk of reoffending on release.
(To the governor)

Notable positive practice

1.45 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

1.46 Inspectors found seven examples of notable positive practice during this inspection.

1.47 The work undertaken by the charity 'Belong', such as restorative justice training, mediation, and one-to-one sessions on conflict resolution, promoted positive ways of resolving disputes and preventing future violence. (See paragraph 3.16.)

1.48 The deputy governor scrutinised all incidents of force used against black and minority ethnic prisoners, which provided additional assurance and oversight. (See paragraphs 3.24 and 4.39.)

1.49 The provision of an extended range of visiting health consultants, including a gastroenterology consultant, pain consultant and muscular skeletal specialist, enhanced confidentiality, enabled multidisciplinary working and improved waiting times for specialist care. (See paragraph 4.62.)

1.50 A mental health professional saw all new arrivals, which is not a practice that we routinely see in category C establishments. This made sure that all arrivals had an early opportunity to discuss their mental health and well-being, which enabled prompt referrals to appropriate services. (See paragraph 4.72.)

1.51 Prison leaders had prioritised time out of cell for prisoners, making sure that cohorting arrangements provided around seven hours a day, which was better than most prisons during the pandemic. (See paragraph 5.1).

1.52 The uptake of video call visits was better than we often see. Facilities were located on each wing to maximise access. Visits could be booked by either the family or the prisoner, and there was no restriction on the number of calls each prisoner could make. (See paragraph 6.4.)

1.53 All prison offender managers now received regular supervision from the senior probation officer, and a monthly team meeting included speakers from other departments to improve awareness of how departments could work together more effectively. (See paragraph 6.12.)

Section 2 Leadership

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

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

2.2 Prison leaders had worked well in partnership with the health provider and Public Health England in the effective management of three COVID-19 outbreaks at Coldingley. There was an appropriate use of lateral-flow testing, a well-promoted vaccination programme and general compliance with infection procedures. Leaders had successfully balanced managing the risk of the virus with the benefits of providing a good amount of time out of cell. Although the prison was operating within the restrictions of stage three of the HMPPS national recovery framework (see Glossary), the time out of cell provided was among the best we have seen in the closed estate. The pace of recovery from COVID was impressive.

2.3 The governor was very visible around the prison, which enabled him to share his vision and identify obstacles to delivering the priorities. Most staff supported the prison's rehabilitative aims and agreed that improving the regime and living conditions were the top priorities. Staff were less familiar with the priority to improve diversity and inclusion, and more work was needed to raise the profile of education and encourage prisoners into purposeful activity.

2.4 The culture at Coldingley remained extremely positive, despite the impact of COVID restrictions. Leaders, staff and prisoners had maintained a good sense of community. Only a few staff completed our staff survey and over half of those who did reported low morale. However, most of those we met had not let this affect their work or commitment.

2.5 The reinstatement of senior officers on residential wings had facilitated better communication and support for staff. Formal consultation with prisoners was underdeveloped, but visible leadership, good relationships and decent time out of cell enabled prisoners to voice issues informally and most staff worked hard to respond.

2.6 Despite the number of staff in training, on temporary promotion or unable to work, leaders had made sure that prisoners were not locked in cell all day as a result. That said, some vacancies had led to poorer outcomes in areas such as education and reducing reoffending.

2.7 Leaders had developed constructive relationships with key partners and voluntary organisations, which had resulted in good outcomes in

areas such as safety and prisoner health. However, some partnerships, such as those with the facilities provider Government Facility Services Limited (GFSL) and the education provider, had not led to sufficiently good outcomes. Relationships with GFSL were cordial, but too many areas of the prison needed repair and refurbishment. The education provider was subject to performance improvement measures which, coupled with a vacancy in a key leadership role, contributed to weaknesses in learning and skills. The provision had been repeatedly criticised for failing to deliver a good quality of education, yet prison and education leaders had not provided sufficient clear guidance to enable the local education team to improve their teaching skills. The recent appointment of a very capable head of learning and skills, coupled with the governor's clear interest in education, suggested that outcomes in this area could improve.

2.8 The fabric and design of the prison were not fit for purpose and half the population lived in poor conditions. National leaders had committed significant investment in a five-year plan to improve Coldingley, but it was too early to see the benefits. Leaders and staff made the most of their resources and managed well, despite significant constraints in the regime, IT systems and the built environment. Leaders gathered useful data but did not always use this effectively to inform improvement plans. However, most leaders in the prison were passionate and committed to improving outcomes for prisoners, were keen to learn from others and welcomed the scrutiny provided by our inspection and HMPPS assurance measures.

Section 3 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

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

3.1 COVID-19 restrictions had affected the movement of prisoners around the estate and, coupled with a wing closure to enable refurbishment, this had led to a reduction in the number of prisoners transferring into Coldingley. Reception procedures were designed to accommodate up to five prisoners a day on transfer, but at the time of inspection it was rare for more than five to arrive in a week. This meant that new arrivals were moved through reception quickly and in most cases their property was processed swiftly.

3.2 New arrivals were offered a hot drink in reception on arrival and a meal was ordered and sent to the first night unit. The holding rooms were comfortable and displayed some important information about the prison.

3.3 Reception staff carried out a detailed initial safety assessment to make sure prisoners were safe during their first few days in custody. Although they made some effort to provide privacy, this took place in the open reception area, which inhibited some prisoners from disclosing everything relevant to their safety.

3.4 There was a very good, confidential, initial health screen and a member of the mental health team also saw most arrivals (see paragraph 4.72).

3.5 A Listener (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) was located in reception to help support new arrivals and staff made sure they were accessible. However, the lack of privacy again hampered their ability to maintain confidentiality or for prisoners to feel they could raise all their concerns.

3.6 First night cells were in poor condition; most were dirty, lacked curtains and had broken furniture. Paint was flaking off the walls and there was graffiti, some offensive, scrawled and scratched into the paintwork. In our survey, only 37% of prisoners said that their cell was clean on their first night, against the comparator of 52%. Leaders were responsive to our criticism and began a cleaning and repainting programme on the induction landing before the inspection had finished.

3.7 First night safety procedures were good. All new arrivals were observed at four-hourly intervals as a minimum, which was increased if

staff felt it necessary or if assessment, care in custody and teamwork (ACCT) case management for prisoners at risk was opened. In our survey, 81% of prisoners told us they felt safe on their first night in Coldingley.

3.8 Pandemic infection control measures meant that new arrivals had to remain on the induction unit for at least seven days, until they had negative PCR tests on the first and fifth days after arrival. They could associate with other prisoners on the unit and were unlocked for around seven hours a day, which was much better than we normally see.

3.9 First night staff conducted an initial induction immediately on arrival. Each prisoner was shown how to use the night sanitation system (see Glossary) and access the phones, which they could do almost immediately to contact their family. Initial induction covered most of the information that prisoners needed and included an assessment to identify those vulnerable to bullying and holding illicit items for others in their cells.

3.10 There was no designated induction office for staff to conduct interviews confidentially or facilitate telephone interpreting for prisoners who did not have English as their first language.

3.11 Prisoners were moved from the induction wing on day seven to commence the second part of their induction. This took place in the education department and was well attended by staff from several departments, including education, workshops, the employment service, safer custody and the gym. This part of the induction was comprehensive, face to face and peer-led. Given the quality of the induction we observed, it was difficult to explain the survey response which indicated that only half of prisoners thought it covered everything they needed to know about the prison compared with 77% at the last inspection. Leaders attributed this to the reduction from three to five days for the second part of the process to accommodate more small groups of prisoners cohorted in 'bubbles' as part of infection measures.

Managing behaviour

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

Encouraging positive behaviour

3.12 Since our last inspection, the rate of prisoner-on-prisoner assaults had decreased by 20% and was lower than in most similar prisons, but we considered around 40% of incidents to be serious. The rate of assaults on staff had almost doubled since 2017 and was now similar to other comparable establishments, although few of these incidents were serious.

3.13 During our inspection, most prisoners were unlocked, and the wings were calm and settled. In our survey, 10% of prisoners told us they felt unsafe at the time of the inspection. As at the last inspection, drug-related debt was the main cause of violence and there remained some weaknesses in the response to the supply of illicit substances. (See paragraph 3.31 and key concern and recommendation 1.34.)

3.14 There was an appropriate focus on identifying prisoners who could be vulnerable to bullying, especially at induction (see paragraph 3.9). There were robust systems to identify and report prisoners presenting with unexplained injuries. Support plans were opened for those identified as vulnerable, which ensured that staff maintained meaningful daily contact and made referrals to other sources of support such as substance misuse services.

3.15 The outdated sanitation system on four of the main wings (see paragraph 4.8) meant it was difficult to isolate individual prisoners in their cells during the day, or supervise them adequately at night. This limited where perpetrators or victims of bullying could be located and therefore most transferred to the segregation unit or, in the case of some victims, to E wing where staff could supervise them more effectively.

3.16 The work of the charity 'Belong. Making Justice Happen' provided valued additional support for both staff and prisoners. This included restorative justice training, mediation services and one-to-one sessions on conflict resolution, emotional regulation and trauma. Although COVID restrictions meant they could not provide their full range of interventions, their work was well embedded in the prison's response to violence.

3.17 Challenge, support and intervention plans (CSIPs, see Glossary) were raised for the most serious perpetrators, but there were weaknesses in their effectiveness. Target setting was poor, investigations into violent incidents took too long and prisoners who had been on a CSIP told us they were unsure what it was for. However, there was work to address the weak implementation, including staff training focusing on improving the quality of behaviour targets, increasing scrutiny of the timeliness of investigations, and a more robust quality assurance process.

3.18 During the inspection, we witnessed some low-level poor behaviour that went unchallenged by staff (see paragraph 4.2 and recommendation 4.5). The prison operated a traditional HMPPS incentives scheme which, on its own, did little to motivate prisoners. In our survey, only 43% of prisoners said that the incentives or rewards in the prison encouraged them to behave well. However, it was the culture at Coldingley that influenced the behaviour of the majority: a good amount of time out of cell, positive relationships with staff, extensive work opportunities and the chance to progress to better living conditions on E and G wings encouraged most prisoners to comply with the rules of the prison.

3.19 Weekly safety intervention meetings were well attended and provided a forum for discussing how to manage individual perpetrators of violence. However, the minutes showed little evidence of discussions or actions to improve interventions and support for perpetrators or victims of violence.

3.20 Monthly strategic safety meetings were again well attended, including by charity partners and Listeners. An appropriate range of data were presented to the meeting, but it was not analysed effectively to draw out any actions. Leaders missed this opportunity to use the learning from data to inform the prison's violence reduction strategy, which had recently been updated but was largely generic. Some aspects of the strategy, such as a violence reduction exit survey, were not applied. The violence reduction action plan derived almost solely from audit findings alone and did not sufficiently capture the prison's wider risks in order to reduce violence. It was also unclear who was responsible for the actions in the plan or where progress was monitored to ensure targets were delivered.

Adjudications

3.21 There had been 392 adjudications in the previous six months which, despite a reduction in population, was a 50% increase since our last inspection. Charges were dealt with quickly and very few adjudications were outstanding. The records we looked at showed that hearings were conducted fairly and adjudicating governors considered the underlying causes of prisoners' poor behaviour rather than focusing on the immediate charge, which was positive.

3.22 A range of relevant and potentially useful data was presented at a quarterly adjudication standards meeting, but there was insufficient analysis to monitor emerging patterns in the use of adjudications adequately.

Use of force

3.23 There had been a slight increase in the of use of force since our last inspection, but overall rates were lower than most comparable prisons. Very few incidents led to full restraint. In the cases that we examined, staff made effective use of de-escalation techniques and used low-level guiding holds appropriately to ensure the safety of staff and prisoners.

3.24 The prison had introduced PAVA incapacitant spray two years previously but there had been no recorded incidents of use, and it was positive that staff did not rely on it to control prisoners. There had also been just one incident involving drawing a baton to prevent injury to staff, and no use of special accommodation.

3.25 Effective scrutiny by senior leaders made sure that all staff statements relating to force were completed promptly. The deputy governor reviewed any incidents of force used against black or Asian prisoners within 72 hours, which showed good leadership in the work to ensure equality. Senior leaders, including the governor, conducted a 10%

review of all other incidents at the monthly scrutiny meeting. Due to the low rates, all incidents of force were reviewed in full. As we identified in 2017, a useful range of data that included protected characteristics, reasons for force and staff involved in incidents was presented to the scrutiny meeting. However, there was still no detailed analysis to reduce the use of force further, which was a missed opportunity.

Recommendation

3.26 **Use of force scrutiny meetings should fully analyse the data presented to monitor trends, identify good practice and learn lessons.**

Segregation

3.27 At the time of inspection, four of the seven prisoners in the segregation unit were there for their own protection because they felt under threat from prisoners on residential wings. Staff told us that they would try and relocate such prisoners to E wing before considering transferring them to another establishment, but none had a formal plan for their care or the best route for their reintegration.

3.28 In our survey, 71% of prisoners who had spent one or more nights in the segregation unit said they had been treated well by staff. We observed positive interactions in the unit and staff were knowledgeable about the prisoners in their care.

3.29 The 11 segregation unit cells were clean and relatively spacious. Four had televisions and all prisoners had a radio, but some cells were poorly ventilated and too hot even in cold weather. The communal areas were clean and tidy, but the two exercise yards remained bare and uninspiring.

3.30 Governance of the use of the segregation unit was adequate, with the reasons for segregation detailed appropriately, reviews conducted on time and health care screenings repeated at each review, which was good practice.

Security

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

3.31 The biggest threats to the prison's security remained the supply of illicit items, such as mobile phones and drugs. In our survey, 38% of prisoners said it was easy to get hold of illicit drugs at the prison. Leaders had identified drugs as a known risk, we had highlighted the issue at the previous inspection and there was clear evidence of illicit drug use at the time of this inspection. Despite this, the prison's

response to tackling the supply of illicit substances was primarily reactive and not underpinned by an effective strategy or supply reduction action plan to measure, monitor and address the scale of the problem. (See key concern and recommendation 1.34.)

3.32 Intelligence was processed promptly. The security department had recently delivered training to staff on E wing to improve the quantity and quality of intelligence reports received from staff on this wing. Residential staff were responsible for intelligence-led cell searches but, due to limited resources, they prioritised intelligence relating to mobile phones and weapons over that relating to drugs. Despite some easing of COVID-19 restrictions, the prison was yet to reinstate random or suspicion-led drug testing, which meant that it could not measure the extent or nature of drug use.

3.33 Although there was a body scanner in reception, staff had not been trained to use it effectively. A lack of CCTV coverage and inadequate staff supervision on the upper landings of the main residential wings further demonstrated an inadequate response to drug supply in the prison (see paragraph 4.2 and recommendation 4.5). The prison's work to reduce the demand for drugs was better. The substance misuse team had established excellent working relationships with the prison and had remained on site throughout the pandemic, continuing to see patients one to one (see paragraphs 4.80 to 4.84).

3.34 There was evidence of successful partnership working with the police and the local community, especially relating to a recent spate of drone sightings. The prison had a dedicated police intelligence officer who focused on extremism and shared a police crime officer with HMP Send. Corruption prevention work was effective.

Safeguarding

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

Suicide and self-harm prevention

3.35 There had been two self-inflicted deaths since our last inspection and the prison had completed all the recommendations from the Prisons and Probation Ombudsman's investigations relating to both.

3.36 The rate of self-harm in the previous 12 months was lower than in most similar establishments. However, it was much higher than at our last visit, rising from 13.62 incidents per 100 prisoners then to 38.26 in the previous 12 months. Leaders attributed most of the increase to a small number of prisoners who prolifically self-harmed, and there was some evidence to support this. Despite good data analysis at the safer custody meeting that informed leaders about the patterns and trends of

self-harm, there was no action plan to reduce levels across the establishment.

3.37 Serious incidents of self-harm were investigated well, and the findings were used to help improve the post-incident care for prisoners in crisis and identify good practice. There were complex case reviews for prisoners who needed the highest levels of support, which were well attended with input from key areas, such as mental health. These reviews identified triggers that could lead to crisis and provided appropriate actions and strategies to address them. A case manager was appointed to ensure continuity of care and the prompt completion of actions.

3.38 Prisoners at risk of suicide or self-harm who were supported by assessment, care in custody and teamwork (ACCT) case management were normally moved to E wing, where staff could supervise them more effectively during the night (see also paragraphs 3.15 and 4.8).

3.39 The quality of the ACCT documents was variable, with both good and poor examples. Some documents had been closed with no actions completed. Others identified actions in the case reviews that had not been recorded on the care plan and so staff were not aware of them and many had not been completed. (See key concern and recommendation 1.35.)

3.40 There was a quality assurance system with management checks on most ACCT documents. The findings from this fed into an overarching action plan, but we found that no actions had been completed and the quality assurance had not addressed any of the inconsistencies so far. (See key concern and recommendation 1.35.)

3.41 Support plans were opened on prisoners who were not in crisis but were vulnerable due to a specific incident, such as a bereavement. These plans identified triggers to staff and ensured a higher level of supervision and meaningful contact, which prisoners appreciated.

3.42 The prison had no constant watch cells, where prisoners at the greatest risk of harm to themselves could be continually supervised by staff. Prisoners who required this level of observation had to move to another prison, which had the potential to increase their levels of anxiety. Prisoners told us they would hide their true level of crisis so they did not have to move from Coldingley for constant watch, which was concerning.

3.43 The prison had a team of 14 Listeners, including one based in reception and one in the segregation unit. The scheme was well established and supported by Coldingley staff and the Samaritans, who met them weekly to provide oversight.

Protection of adults at risk (see Glossary)

3.44 The prison had an excellent adult safeguarding policy and staff knew how to make both social care and adult safeguarding referrals to the

local authority. The deputy governor attended the Surrey safeguarding adults board.

Section 4 Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

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

4.1 In our survey 82% of prisoners said that staff treated them with respect and that there was a member of staff they could turn to if they had a problem. We observed positive relationships between staff and prisoners, and most staff had good knowledge of the prisoners in their care. The atmosphere on wings was pleasant and we saw staff helping prisoners with their queries. We observed several positive interactions and prisoners pointed out staff who had been very helpful to them. Prisoners were also familiar with members of the senior leadership team.

4.2 However, there were some gaps in staff supervision. For example, staff did not always challenge low-level poor behaviour such as vaping, and supervision on the upper landings of residential units was not consistent. Prisoners had damaged CCTV on the older residential units which, combined with poor building design, contributed to the challenges of supervision. (See paragraph 3.33.)

4.3 The prison had employed several peer workers, but their effectiveness varied according to the department that managed them. Peer workers were not particularly visible and difficult to identify on the wings. There was no one point of contact in the prison who had strategic oversight of peer work, which limited their value in the prison community.

4.4 Key work (see Glossary) was inconsistent in the quality and frequency of sessions. The records we examined varied greatly and too often resembled welfare checks without any reference to sentence progression (see paragraph 6.17). Prisoners often saw a different key worker at each session, which hindered the building of rapport. In our survey, only 59% of prisoners said they had a named officer, against the comparator of 78%. Key work was not always prioritised and there was a lack of adequate quality assurance by prison leaders.

Recommendations

4.5 **Effective staff supervision in all residential areas should enable staff to detect and challenge low-level poor behaviour.**

4.6 **Prisoners should be supported by a named keyworker to support their well-being and sentence progression.**

Daily life

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

Living conditions

4.7 Over half of prisoners lived on the older units, A to D wings, where conditions and accommodation remained poor. Cells were small and dingy, and there were several damaged or moulding windows. The malfunctioning heating system, compounded by broken windows, had been a longstanding issue that caused much frustration for prisoners, who complained of being too cold. (See key concern and recommendation 1.36.) The prison had provided additional blankets and hot water bottles, but this was still not sufficient. More positively, most cells were single occupancy and prisoners had access to a privacy key. Staff and prisoners made some efforts to keep wings and cells clean, despite the poor conditions.

D wing cell windows

4.8 The older units did not have in-cell sanitation. All toilets, sinks and showers were communal. Prisoners relied on an electronic unlocking system when locked up, which required them to press a button and queue before being unlocked for the eight minutes allowed to use the facilities. Since the onset of the pandemic, the prison had also allowed prisoners to use the landing phones during this designated eight

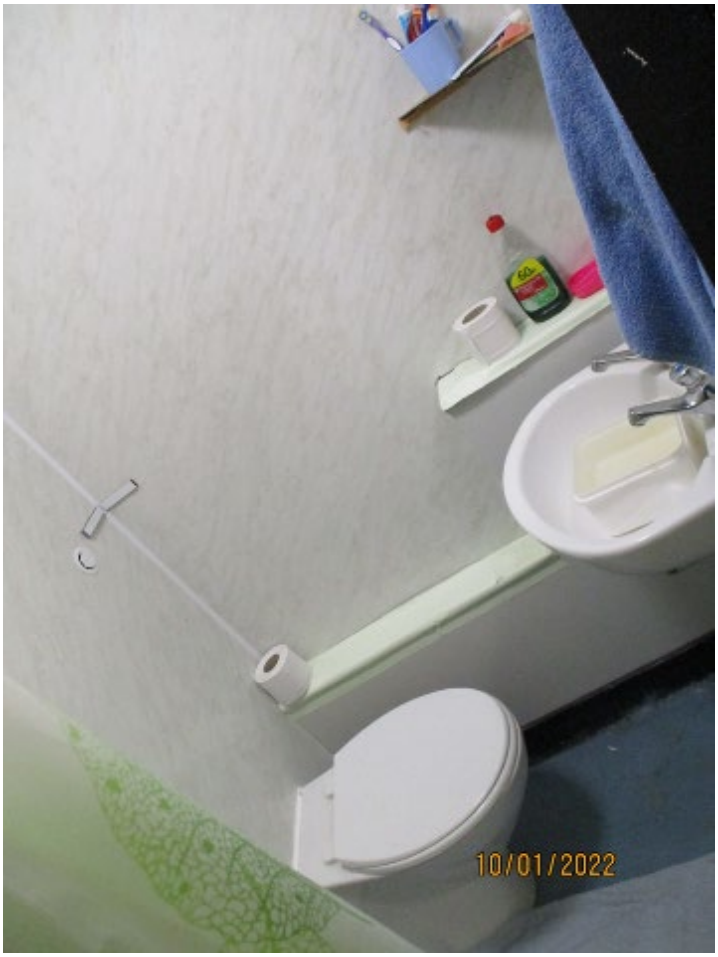
minutes, which increased the number of prisoners joining the electronic queue. Prisoners reported lengthy waiting times to use the toilet and, although they had been provided with buckets to use in their cell, they had nowhere to wash their hands. There were well-developed and funded plans to install in-cell sanitation over the next five years. (See key concern and recommendation 1.36.)

C wing communal toilet

4.9 Showers on the older units had been recently refurbished and were in good condition. There were some out-of-use urinals, a blocked sluice and broken toilet seats, but most toilets were kept clean. Some of the refurbished communal toilets did not have adequate screening.

C wing sluice

4.10 Living accommodation on E and G wings was better. G wing provided mobile pod units that were new, in good condition and included individual toilets, sinks and showers. There was a small unit for self-catering facilities but no other association space. E wing benefited from in-cell toilets and showers, cells were much more spacious and well equipped, and prisoners were positive about the living environment.



E wing in-cell toilet and shower

4.11 Communal areas in most wings were generally tidy. With the exception of G wing, all units had association rooms, which were often empty and bare. All units had well-used self-catering facilities, including fridges, microwaves, toasters and a hot plate, plus an oven appliance for E and G wings.

C wing self-catering facilities

4.12 The external areas were reasonably clean and the prison was replacing some window grilles where rubbish and dirt had built up. Exercise yards were clean and most were fitted with some gym equipment. Some internal areas had been improved by inspiring pictures, but too many communal areas were uninviting with torn posters, and some wing offices were messy and had damaged furniture.

Outdoor area

4.13 The prison was starting to install in-cell telephones, but at the time of inspection prisoners still used landing phones, or prison mobile phones for those on E and G wings.

4.14 There were sufficient cleaning supplies available to prisoners, with large detergent dispensers in the communal areas. Prisoners had access to clean clothing, although since COVID restrictions were imposed, the process to request fresh laundry and kit was by application; this varied on every wing and not all prisoners knew how to request it. All wings had their own laundry facilities, which offset the inefficient kit change process.

4.15 Response times to cell call bells were not recorded or monitored, and in our survey only 25% of prisoners said they were answered within five minutes. During patrol state on the older units, staff had to pause the sanitation system in order to answer cell bells.

Residential services

4.16 In our survey, 61% of prisoners said the food was good against the comparator of only 34%. Portion sizes were reasonable and 52%, compared with 37% in similar prisons, said they had enough to eat. The menu had an appropriate variety of options, including a warm choice at lunch time, and a 'weekly jacket potato' day. Prisoners made good use of the self-catering facilities and were often gathered around these areas cooking for themselves and their peers.

4.17 The older accommodation had a central servery overseen by kitchen staff, which was clean and in good order. Prisoners in these units collected their hot meal and were locked behind their doors unable to wash their hands or crockery. E and G wing prisoners collected their meals, and the prison had just invested in new trollies to keep the food hot in transportation. Communal dining areas had not been used since the onset of the pandemic.

4.18 Staff supervision at mealtimes was adequate and catering staff regularly attended food serving points. Most servery workers wore the correct personal protective equipment when handling food, although E wing had missing utensils and we were not assured that servers followed correct protocols. Prisoners who worked in the kitchens had the option to take up level two national vocational qualifications (NVQs).

4.19 Prisoners could order a range of goods through DHL and a variety of online retailers. In our survey, only 52% of prisoners overall said that the shop sold the things they needed. Black and minority ethnic and Muslim prisoners continued to have worse perceptions – only 36% of minority ethnic against 67% of white prisoners, and 27% of Muslims against 60% of non-Muslims, said the shop sold what they needed. The prison needed to do more to understand why so many prisoners did not feel catered for. Prisoners had not been consulted on the shop and there was no evidence that the prison reviewed the items on sale. Prisoners said that items were often out of stock and had been

removed from the lists recently. They were not always able to shop from catalogues and had to ask staff or family and friends to look up items for them.

Prisoner consultation, applications and redress

4.20 Three general prisoner consultation meetings had taken place in the last 12 months, chaired by the governor. They had delivered important updates about the pandemic to some prisoners, but the agenda left insufficient room for consultation on matters that prisoners wanted to bring to senior leaders' attention. The lack of attendance from other key prison leaders to take up action points was also unhelpful to prisoner representatives.

4.21 Prisoner representatives had not received training or guidance for the consultative role and many told us they were unclear about how they should participate at the meetings. Prison leaders responded positively to this feedback, committing to improve both consultation and training for representatives.

4.22 There had been 1,384 complaints submitted in the last 12 months, which was higher than similar prisons, but similar to our last inspection. Most complaints were about property, residential problems and employment. There had been some analysis by managers to identify themes, but there had been little scrutiny to resolve the root causes.

4.23 The complaints system had been recently reviewed and the quality assurance system had identified some unacceptable replies from prison staff. In our survey, only 20% of prisoners said that their complaint was answered within seven days and many told us they had little confidence in the system. Some of the responses to complaints we sampled encouraged prisoners to submit further complaints if they felt unsatisfied, rather than committing to a full resolution from the outset. This resulted in several prisoners submitting multiple complaints about the same matter.

4.24 The application process for prisoners' queries had become unwieldy and leaders had lost grip of oversight. Prisoner applications were logged electronically, but records of staff responsible for replying or the date the reply was sent to the prisoner were not maintained. It was difficult to assess how long each application typically took to deal with. We found unanswered application forms dating back to October 2021, as well as some answered applications among the unanswered ones, exacerbating delays.

4.25 Legal rights arrangements were reasonable. Many prisoners we spoke to said the provision was sufficient. The five legal visit booths had been refurbished to a good standard and prisoners were able to have meetings or view CCTV with their legal representative in private. The library held several legal books for prisoners to access. In our survey, 53% of prisoners said their legal documents had been opened by staff; we found that prison staff kept good records of letters opened in error

and sent an apology to prisoners when this happened. Greater managerial oversight was required to minimise such errors.

4.26 Video conferencing was available and there had been good use of this facility, particularly at the height of COVID restrictions.

4.27 The prison had one 'access to justice' laptop (to assist prisoners with their legal representations) and records showed it had been issued to help prisoners research their legal rights.

Recommendations

4.28 **Responses to prisoner complaints should be prompt and fully address the issues raised.**

4.29 **The prison should track prisoners' application forms so that leaders are clear about the nature of the problem, promptness and quality of responses.**

Equality, diversity and faith

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

Strategic management

4.30 Work to support and promote equality had been adversely affected by the pandemic and strategic oversight had deteriorated in key areas. The small diversity and inclusion team was led by the head of safety, whose main focus had been on other work.

4.31 The diversity and inclusion strategy was clear about what the prison wanted to achieve, but records showed that the equality action plan (designed to support diversity and inclusion work continuously) had been closed at the last diversity and inclusion committee meeting. When we raised this with leaders, they committed to review the plan at the next meeting.

4.32 The diversity and inclusion committee had met only three times in the last 12 months. Meetings were well attended and looked at relevant data, although there had been delays of up to five months in receiving HMPPS national equality data. The committee did not adequately address issues of disproportionality. Recent local data did not highlight any disproportionate outcomes for prisoners with protected characteristics but monitoring at other meetings, such as the segregation review group, had identified concerns in the past. There was no evidence that these concerns were picked up and dealt with at

the diversity and inclusion meeting. (See key concern and recommendation 1.37.)

4.33 There had been 57 discrimination incident reporting forms (DIRFs) submitted in the last 12 months, which was more than at our last inspection. The forms were freely available on most wings but not all. Some prisoners we spoke to said they had little confidence in reporting discrimination, believing that there would be repercussions if they raised complaints about staff. The responses to many of the DIRFS we looked at failed to provide a full and adequate reply. Six had been rejected inappropriately and a small number had resulted in lengthy delays before there was a response to the prisoner. The Independent Monitoring Board had scrutinised some of the DIRFS and had identified important concerns about the investigations, but it was unclear what remedial action followed.

4.34 The diversity and inclusion team was supported by named senior managers, each responsible for leading on a protected group. However, they were not actively consulting with the groups they represented, which left prison leaders unsighted on the specific needs and experiences of some prisoners. This was somewhat offset by several examples we saw in prisoners' case notes of staff providing good informal support. The role of prisoner equality representatives was underdeveloped. (See key concern and recommendation 1.37.)

4.35 The celebration of diversity and inclusion events had been meagre or non-existent. Black History Month had been marked by just a few posters, even though Black Lives Matter was high profile in the media. Leaders had published a calendar of cultural awareness events for the forthcoming year and were optimistic that they would deliver more interesting and informative sessions to prisoners in the future.

Protected characteristics

4.36 Almost half of prisoners were from black or minority ethnic backgrounds, 13% were foreign nationals and 25% were Muslim. In our survey, racial minority prisoners reported similar perceptions to white prisoners, and this was mirrored in prison data for segregation, adjudication awards and IEP. The deputy governor scrutinised all incidents of use of force against black and minority ethnic prisoners, providing additional assurance and oversight, which was notable positive practice. Before COVID restrictions were imposed, black community speakers had given some excellent support to black and minority ethnic prisoners, which they valued. Leaders said they looked forward to inviting the guests back as soon as they could. Some Rastafarian prisoners reported frustration about gaps in understanding and support for their religion, such as the importance of their dietary needs and specialist hair products: leaders were urged to investigate this further.

4.37 Gypsy, Roma and Traveller prisoners we spoke to felt marginalised, and were offended by the 'Gypsy soup' that featured on the menu.

Prison managers agreed to meet with this group of prisoners to understand and address their concerns.

4.38 The 33 foreign national prisoners at the prison had been provided with two drop-in face-to-face Home Office surgeries in the last six months. The commitment to arrange and facilitate these during the pandemic was commendable. There were no records of the use of interpreting or translation services. The prison said there had been no prisoners who could not speak English but were adamant that they would use the services if needed. As a minimum, the prison should have core texts, such as the induction booklet, translated into the main foreign languages.

4.39 There were two adapted cells for disabled prisoners on E wing. Both were occupied by wheelchair users who said their needs were being fully met and felt supported by staff. At the time of our inspection, 15 prisoners required personal emergency evacuation plans. Those we examined were appropriate and up to date, and staff knew which prisoners would need assistance in an emergency.

4.40 There was a named prisoner representative for LGBT prisoners, and it was notable that he felt comfortable at Coldingley and could be open about his sexuality. However, the absence of forums and restrictions on where he could go around the prison meant that he was unable to see prisoners discreetly when they requested his support.

4.41 There was one transgender prisoner at the prison. Work to support and promote equality. A senior leader had managed the ordering of toiletries and her other material needs, but this arrangement was impractical because it was harder for prisoners to speak with senior leaders and her requests to do so were delayed. A simplified system to manage her requests through wing staff with appropriate training was needed.

Faith and religion

4.42 A dedicated, well-led chaplaincy provided strong pastoral and spiritual support to prisoners. Their work was well integrated within the wider prison community. Chaplains saw all new arrivals face to face within 24 hours and attended ACCT reviews where appropriate.

4.43 Access to corporate worship had been well managed and had continued to be delivered over the last six months. In our survey, 78% of prisoners said they could attend religious service if they wanted to, against the comparator of 56%.

4.44 Many prisoners gave us examples of where chaplains had supported them through bereavement or when they were struggling during the pandemic, which they valued. The facilities for worship and quiet reflection were equally excellent in the mosque, chapel and multi-faith room.

4.45 The chaplaincy provided a good stock of religious items, such as prayer beads, prayer mats and faith books, and were responsive in ensuring prisoners received them promptly. They also supported the prison to find suppliers for religious garments that prisoners could purchase if they wished.

Health, well-being and social care

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

4.46 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC issued 'requirement to improve' notices following the inspection (see Appendix II: Further resources).

Strategy, clinical governance and partnerships

4.47 Leadership and strategic oversight of health care arrangements were good and had provided effective monitoring throughout the pandemic. Central and North West London NHS Foundation Trust (CNWL) provided primary care and mental health services; Forward Trust provided clinical and psychosocial substance misuse services; and Tooth and Mouth were responsible for dental services.

4.48 Public Health England, CNWL and prison leaders had worked well together to manage three COVID-19 outbreaks, and this partnership had also been effective in delivering the COVID-19 vaccination and booster programme. Staff and patients across the establishment were familiar with the lateral-flow testing requirements as well as the process if a prisoner reported COVID-19 symptoms.

4.49 We were told that plans for the restoration and recovery of health services focused on increasing the number of clinical appointments to improve response times and availability of services.

4.50 The head of health care provided clear leadership to a committed and caring team. We observed conscientious staff who knew their patients well. Clinical supervision and mandatory training had been maintained throughout the pandemic, which was good and supported safe practice.

4.51 The health centre was clean, and the health care orderly maintained a high standard of hygiene across the department. A 2021 CNWL infection control audit had identified several issues, which had been addressed, with the final item of torn flooring replaced during the inspection.

4.52 Patients were consulted through a forum facilitated by EP:IC, a patient consultation body, which had identified difficulties in obtaining health

application and complaint forms on the wings. The head of health care said that this issue had been completely missed at the start of the pandemic and that, although application and complaint forms had continued to be delivered to health care, the process was not always confidential. Post boxes had been ordered for each wing but were not yet in place and we were told that this was a matter of urgency. An interim measure to provide prisoners with an envelope to submit forms did not happen consistently. Responses to complaints addressed the concerns identified by the patient, were respectful and written in plain English.

4.53 There were SystmOne clinical records for all patients, although Forward Trust maintained a separate system to collect data and for psychosocial interventions. Although the Trust recorded clinical interventions, patient risk factors and a summary of interventions on SystmOne, the maintenance of two recording systems was a risk and not best practice.

4.54 Emergency resuscitation equipment was in good order and checked regularly but the emergency bag weighed 15.5kg, which was heavy and presented a health and safety risk to staff carrying it during an emergency call.

Recommendations

4.55 **Patients should be able to make a confidential complaint or application for a health care appointment.**

4.56 **All patient care should be recorded on SystmOne to maintain the integrity of a single clinical record.**

Promoting health and well-being

4.57 There was no prison-wide approach to promoting health and well-being, but a strategy had been developed and was due to be implemented on the arrival of a new health care assistant. There were plans to follow the national health promotion calendar.

4.58 Forward Trust displayed a range of health promotion material across the prison. CNWL also displayed some health promotion material, mainly in the health care and reception areas.

4.59 The uptake of non-COVID immunisations and vaccinations was good. A range of prevention screening programmes included retinal screening, and waiting lists were low. NHS sexual health, age-related health checks and physical health checks for patients on mental health medication were routinely offered to monitor patients.

Primary care and inpatient services

4.60 Qualified nurses saw all new arrivals in reception and used the national screening templates in a confidential clinical environment. The reception screening included a lateral-flow test for COVID-19 and made any appropriate referrals. There was no information leaflet to tell new

arrivals about the health services available, which was a missed opportunity. The GP routinely screened most clinical records for new arrivals for assurance.

4.61 The well-led primary care team had no staff shortages as recent vacancies had been filled. Staff felt well supported and morale in the team was good. Each nurse had allocated areas of responsibility to ensure accountability. A range of services were available and delivered within a centralised health unit, which worked well. A few patients told us Coldingley provided one of the best health care in prison they had experienced.

4.62 Secondary care appointments were managed effectively by an administrator. The service had more than average visiting consultants, including a gastroenterology consultant, pain consultant and muscular skeletal specialist, which improved confidentiality, enabled multidisciplinary working and improved waiting times for specialist care. Although pain management reviews were still undertaken, patients were now seen separately by clinicians rather than within multidisciplinary team complex case reviews; it was unclear if there were plans to reinstate this. External secondary care appointments had a high non-attendance rate with an average of 41% cancelled between July and November 2021 due to a lack of escort staff. The senior team had identified the risk but it remained unresolved.

4.63 Some clinical time was lost due to the lack of free-flow prisoner movement during the pandemic restrictions and the reliance on prison staff to escort all patients to health care.

4.64 Most waiting times were short and patients could see a GP or nurse on the day, Monday to Friday, if urgent. However, podiatry had a wait of 20 weeks and the optician also carried a waiting list of over a year, which was poor.

4.65 Long-term conditions were managed well. Primary health care quality and outcomes framework codes were not used to identify patients with such conditions, although new arrivals were placed on a caseload. The clinical records we saw were comprehensive and well written, and almost all patients had a care plan.

4.66 There were currently no patients with end-of-life care needs, but there were contingencies to cover this. Prisoners due to be released were flagged within a multidisciplinary team process to make sure that all take-home medications were ready, there was liaison with community health services and follow-up appointments were in place, which was good practice.

Recommendation

4.67 **Patient access to external appointments, assessment and treatment should not be delayed by the lack of escorts.**

Social care

4.68 Social care arrangements were informed by a memorandum of understanding between Surrey County Council and the prison, which had been reviewed and signed in September 2021. Surrey County Council delivered the domiciliary care and there were seven prisoners receiving support.

4.69 We were told that referrals for social care assessments came from the prison and prisoners could also make self-referrals. The local authority sought additional information from health care and the prison to screen referrals and visited all those who made a self-referral. Prisoners told us that support care packages had been maintained throughout the pandemic and that they appreciated the reliability of the service.

4.70 Mobility equipment and other aids were provided promptly and the occupational therapist visited to make sure they were used safely.

Mental health care

4.71 Mental health services were delivered by a small but dedicated team on weekdays who operated the stepped-care delivery model. There had been staffing shortages in the psychology team commissioned to deliver primary mental health care and the manager was currently on long-term sick leave. A registered nurse delivered secondary mental health care.

4.72 All new arrivals were offered a screening with a mental health professional, exemplifying good practice. This ensured that all arrivals had an early opportunity to discuss their mental health and well-being which enabled prompt referrals to appropriate services. A bank nurse ran daily wing drop-in clinics, which provided a safe space for patients to get support.

4.73 An open referral system meant that anyone could refer to the team and all new referrals were discussed during the weekly multidisciplinary team meeting. Clinical decisions were well documented on the electronic patient record.

4.74 Gaps in psychological therapy provision had resulted in unmet patient need, with no psychology staff to provide primary mental health care for several months. A psychologist and an assistant psychologist had joined the team in the previous month. Recruitment was ongoing for a forensic psychologist post that had been vacant for about a year. As a result of these staff shortages, approximately 40 patients assessed and accepted for psychological therapy were waiting for their treatment to start – 17 had waited for over three months for their therapy, with one waiting for 13 months, which was unacceptable. A further 15 patients were awaiting an assessment for psychological therapy. (See key concern and recommendation 1.38.) The new staff were actively addressing this backlog, and patients had received intermittent welfare checks and communication in the meantime.

4.75 Counselling provision was available with nine patients receiving regular support and a further five on the waiting list. A learning disability nurse offered a neurodiversity pathway to around 10 patients.

4.76 Patients receiving secondary mental health care for severe and enduring mental illness were allocated a care coordinator and had comprehensive personalised care plans. Those we spoke with said they felt well supported by mental health nurses at Coldingley. Secondary care was overseen by an experienced psychiatrist, who had excellent knowledge of the patients. There was no waiting list to see the psychiatrist.

4.77 The mental health nurses attended all initial ACCT case reviews as well as those for patients receiving secondary mental health care.

4.78 There was a dual-diagnosis pathway to support prisoners with mental health and substance misuse issues. The two teams worked well together to support approximately 15 patients, who all had a care plan.

4.79 In the last 12 months, no patients had been assessed as requiring a transfer to hospital for treatment under the Mental Health Act.

Substance misuse treatment

4.80 The Forward Trust delivered an integrated clinical and psychosocial substance misuse service providing a good standard of care and treatment. The staff had established excellent working relationships with the prison. The substance misuse team had remained on site throughout the COVID-19 pandemic and had continued to see patients one to one with appropriate safety measures in place.

4.81 The team supported approximately 130 patients, including 22 receiving clinical treatment. Referrals were received from new arrivals but could also be made by any prisoner or staff member. A daily handover meeting reviewed all new referrals and discussed any concerns or matters arising.

4.82 Psychosocial support had been delivered in groups before the pandemic but had been delivered one to one since April 2020. A range of self-help literature and workbooks were available. There were plans to recommence groups including mutual aid, such as Narcotics Anonymous and Alcoholics Anonymous, as soon as the prison allowed this.

4.83 Peer workers supported patients on the substance misuse caseload and received good training and support from the team to carry out their roles.

4.84 The clinical team saw patients in receipt of opiate substitution therapy (OST) on their arrival to the prison and they received medication in line with their prescription without delay. There were currently 22 patients receiving OST, with the majority on a maintenance programme. Prescribing was flexible and patient-led with regular reviews. We

observed competent administration of OST with appropriate prison officer supervision of medicines queues.

4.85 The service manager and a recovery and well-being practitioner attended monthly drug strategy meetings and were involved in the current review of the wider prison drug strategy. Although an incentivised substance-free living wing had been established since the last inspection, progress to implement this fully had been halted during the pandemic. Patients signed a compact to live on the enhanced wing, but additional activities were limited and some prisoners resided on the wing for other reasons, such as social care needs.

4.86 Data and our inspection survey results indicated that illicit drug use had risen at Coldingley. The substance misuse team saw prisoners to offer harm-minimisation advice where intelligence from the security team suggested illicit substances had been used.

4.87 Pre-release planning was good with arrangements made to continue OST if required and provide naloxone (a medicine to reverse the effects of opiates).

Medicines optimisation and pharmacy services

4.88 Strategic governance and oversight of the pharmacy were good. Regular, well-attended medicines management meetings shared prescribing reviews, learning from incidents and alerts and service improvement progress. Some local medicines practices were less robust, such as the repair of storage cupboards and resetting of fridge temperatures, but these were promptly resolved once we had identified them.

4.89 Medicines were accessible Monday to Friday, with contingencies for the rare late arrivals to the prison or out-of-hours prescriptions. Pharmacy staff undertook the medicines reconciliation within 72 hours of the prisoner's arrival. Clearly labelled boxes held patient-named medicines and most had patient information leaflets. There was a weekly pharmacy visit from the lead pharmacist, who was also available for advice during the week, and a pharmacy technician managed the stock, returns and disposal in line with the local standard operating procedure.

4.90 Medicines were safely administered three times a day. Most patients received their medicines in possession, in line with their risk assessments. More patients than we would expect were administered daily in-possession medicines; we were told that this was a temporary measure to reduce repeat attendances during COVID-19 outbreaks. We observed a small number of patients waiting for medicines and their queries were addressed and managed promptly. Officers were present during administration but were not wholly involved in monitoring supervised consumption.

4.91 Emergency drugs were held within the cupboards and emergency bags were checked weekly. Controlled drugs were administered from

named-patient boxes and were stored and managed robustly within the national guidelines. A controlled drugs logbook was used to manage and check stock levels and logging errors were mostly managed within guidelines. Provision of medicines for prisoners to take home on release or discharge was managed well.

Dental services and oral health

4.92 Tooth and Mouth Dental Group was commissioned to provide dental services two days a week. The waiting list for routine or treatment appointments was six weeks, which was reasonable. The dental team had recommenced aerosol-generating procedures (see Glossary) in June 2021, which had enabled them to reduce the waiting list for treatment.

4.93 Patients experiencing dental pain were given over-the-counter painkillers and triaged. Those requiring urgent assessment and treatment were seen in an emergency appointment during the dental clinic. The clinical records we looked at confirmed that appropriate antibiotics and pain relief were prescribed. Oral health promotion was delivered during appointments, as well as advice on obtaining follow-up treatment on release from prison.

4.94 The dental clinic met infection-control standards. Staff completed decontamination audits and equipment checks to make sure safety standards were met and adhered to.

Section 5 Purposeful activity

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

Time out of cell

Expected outcomes: All prisoners have sufficient time out of cell (see Glossary) and are encouraged to engage in activities which support their rehabilitation.

5.1 Leaders had prioritised prisoner time out of cell despite the COVID-19 restrictions and had been creative with cohorting arrangements to maximise this. Prisoners on the older units were secured on to their landing in cohorts, which allowed them all to be unlocked for most of the day. Risk-assessed prisoners located on G wing were unlocked all day and during our roll checks we found just 4% of prisoners locked up. Most were unlocked for at least seven hours, which was better than we have found in most closed prisons.

5.2 COVID-19 restrictions had limited employment opportunities and we identified that only 30% of prisoners were engaged in purposeful activity. Although prisoners were very grateful not to be shut up in small cells all day, some reported feeling bored because they were not in work or education. G wing did not have a dedicated exercise yard or gym equipment.

5.3 Most prisoners had been able to visit the library in person weekly since October 2021. Despite a reduced range of library activities due to COVID restrictions, access to the facility had been well promoted by an onsite librarian. This commitment led to better attendance than we have found elsewhere during regime recovery. This was reflected in our survey, in which 55% of prisoners said that they could visit the library at least weekly, against the comparator of just 12%. While the successful library magazine used to promote literacy had stopped production due to funding issues, other methods to encourage engagement had continued. These included Storybook Dads, enabling prisoners to record a story for their children, and regular writing competitions.

5.4 Prison data showed that the average attendance for physical activity was 49% in the previous 12 months, compared with around 70% before COVID-19 restrictions were imposed. The reduction reflected the many regime restrictions and the frequent redeployment of PE staff at the peak of the pandemic. Nevertheless, access to the gymnasium was improving. All prisoners (except those isolating due to COVID) could now use the internal gym facilities at least twice weekly, rostered by wing, and we were satisfied that there was equitable access. The

prison still lacked facilities for outdoor sport but, apart from shower areas, most indoor PE facilities were good.

5.5 PE staff were active in supporting the prison's COVID recovery plan. Prisoners were due to commence the Football Association twinning project with AFC Wimbledon to promote physical and mental well-being and support learning. There had also been recent investment in IT to support the delivery of sports-related accredited learning as part of the recovery plan.

Education, skills and work activities

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

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

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

Overall effectiveness: inadequate

Quality of education: inadequate

Behaviour and attitudes: inadequate

Personal development: inadequate

Leadership and management: inadequate

5.7 Leaders and managers did not make sure that teaching and training were of sufficiently good quality. While they had identified that the quality of teaching did not meet their expectations, they had not taken effective action to secure improvements. Leaders and managers did not help teachers and instructors to improve their teaching and assessment practices. Professional development for staff in education was focused on operational practices rather than on teaching. Leaders and managers applied insufficient oversight to the quality of activities

outside of education. They did not monitor effectively the quality of teaching and assessment or the progress made by prisoners in prison-led activities. (See key concern and recommendation 1.39.)

5.8 Leaders had created the opportunities for prisoners to engage in education or work roles and there were enough spaces on a part-time basis for all the population. They had maintained a broad range of education programmes, available for prisoners to attend face to face in wing-based cohorts once a week, with in-cell self-study materials to consolidate their learning. However, too many prisoners chose to remain unemployed. Attendance at education, skills and work activities was poor because too few prisoners valued their learning opportunities. Leaders had not effectively sought to establish why prisoners' attendance was so low. (See key concern and recommendation 1.40.)

5.9 Prisoners allocated to education had a poor attitude towards learning. Those who did attend were insufficiently prepared to learn and did not take responsibility for their own learning. They could not recall what they had covered previously and rarely completed work set for them between lessons. Teachers did not hold prisoners to account for completing the work set. As a result, too many prisoners failed to make progress in their studies.

5.10 The education, skills and work offer was well informed by local labour market intelligence and prisoner needs. Leaders and managers at the prison worked effectively with each other, their education partners and a range of subcontracted providers to establish new learning programmes, such as roofing, multi-skills and forklift training. Leaders were proactive in enabling new provision to run quickly.

5.11 In contrast, leaders did not provide sufficient education to the high proportion of prisoners with the lowest levels of literacy and numeracy. Only a few prisoners could access face-to-face English and mathematics classes, and there were far too few lessons available for those at entry level. While an English and mathematics teacher held small group sessions in the vocational and commercial workshops for prisoners at entry level, too few participated. Managers had very recently reintroduced entry-level functional skills qualifications. Too few prisoners achieved their functional skills qualifications overall.

5.12 The range of prison-led commercial workshops was narrow and not enough qualifications were available to prisoners in these workshops and other work roles. Few prisoners chose to complete a qualification where they were available. The pay policy was not fair and did not incentivise attendance at education; prisoners earned much more if they engaged in work activities.

5.13 Leaders and managers did not make sure that prisoners attended activities that took into account their resettlement needs or aspirations. Prisoners' sentence plans and personal learning plans were not considered when allocating them to activities. Staff responsible for allocating prisoners to activities did not have access to relevant information about their needs. Prisoners were allocated to activities

merely based on the wing in which they resided and where spaces were available.

5.14 Too many prisoners were unaware of their options for education, skills and work at the prison, and did not have a personal learning plan. Where staff had created plans for prisoners, they were often incomplete, did not establish appropriate career goals or set clear plans for progression. The learning plans used in workshops lacked specificity and were not fit for purpose. As a result, prisoners did not know what they were learning, why or how this would help them in the future. Leaders did not monitor how the small number of prisoners released accessed further training and employment in the community.

5.15 Information, advice and guidance staff did not provide prisoners with unbiased careers information. (See key concern and recommendation 1.41.) Leaders had recently improved the induction process for prisoners. Peer mentors involved in the delivery of induction fulfilled this role well, took on a position of responsibility and made clear to prisoners the value of work and education. However, the induction process was too new and had not had yet an impact on the vast majority of prisoners.

5.16 Leaders and managers planned a vocational curriculum that enabled a small proportion of prisoners to develop useful technical skills. For example, they developed skills in warehousing, stock control and how to create customised products such as badges, mugs and printed clothing. The resources in the vocational workshops were excellent and met commercial standards. Prisoners in the 'creator centre' successfully learned how to use highly technical graphic design software. However, prisoners in these workshops did not have the opportunity to achieve an accredited qualification. (See key concern and recommendation 1.42.)

5.17 Too few prisoners developed the knowledge, behaviours and skills required to progress to their next stage of education, training or employment, either in the prison or on release. Instructors did not recognise or record the progress made by prisoners in workshops effectively. (See key concern and recommendation 1.42.) Leaders had recently introduced a 'skills portfolio' to record prisoners' employability skills development. However, instructors had not had training in how to use this, and too few were qualified in teaching or training.

5.18 Prison staff and education staff did not communicate effectively about who was expected to attend education. Prison staff did not do enough to prioritise prisoners' arrival at activities on time, or at all. Prisoners were often due to attend work, medical appointments or visits at the same time as they were scheduled to attend education. Lessons did not commence in a timely manner due to prisoners' poor punctuality. As a result, prisoners made very slow progress in their learning.

5.19 Teachers and instructors did not identify prisoners' knowledge and skills gaps. They did not challenge prisoners through education and work activities and did not plan learning programmes sequentially.

Prisoners did not build on their existing skills and knowledge. In most subjects, topics were disjointed and the curriculum content lacked coherence. (See key concern and recommendation 1.42.)

5.20 Prisoners on distance learning programmes benefited from dedicated teacher support and resources in the distance learning hub based in education. They made good progress in their studies.

5.21 Too few prisoners with additional support needs received the support they needed to progress with their learning. Staff relied too much on prisoners to self-declare their learning needs and did not assess their learning difficulties or disabilities effectively. Staff responsible for identifying and planning support did not have the necessary training or experience. Instructors did not receive any information about prisoners' known needs. Staff did not plan effectively for the deployment of trained peer mentors. Consequently, most prisoners with support needs were not able to engage in learning effectively.

5.22 Most teaching resources used in education were of poor quality. In information technology lessons, teachers used out-of-date resources for prisoners' independent learning from obsolete qualifications that did not reflect the software version prisoners used. In English and mathematics, teachers used materials of variable quality, currency and suitability, from different organisations. The few in-cell learning packs teachers used to support learning between lessons were not appropriate to prisoners' specific levels of learning.

5.23 The small proportion of prisoners in the vocational training workshops worked independently on challenging and complicated tasks. Those working on the wings worked productively on cleaning and laundry tasks and complied with instructions from officers. Prisoners were well behaved in learning and work and were respectful of their peers and teachers most of the time. Teachers tackled any instances of racist or homophobic behaviour by opening useful dialogue with those involved.

5.24 In vocational training, teachers helped prisoners to develop a range of personal and social skills that prepared them well for employment. For example, prisoners understood the need to work together to achieve targets. However, in most of the prison-led commercial workshops, instructors did not make sure that the environment reflected realistic commercial pressures. Prisoners did not develop professional workplace skills that would support them in the workplace in the future. They repeated mundane tasks that lacked challenge.

5.25 Teachers and instructors did not routinely help prisoners to broaden their knowledge about fundamental values, or further their personal and social development. Some staff used ad-hoc opportunities to discuss current news items or topical issues with prisoners. In these instances, prisoners could express their different views and learn about the perspectives of others. However, staff did not teach them how to engage in constructive debate. Prisoners did not learn how to respond positively to conflicting views.

5.26 A minority of teachers used their lessons to teach prisoners about different cultures. For example, in catering, prisoners cooked food from their cultural heritage for their peers. In the packaging workshop, staff discussed with prisoners the different food items eaten by those from different backgrounds.

Section 6 Rehabilitation and release planning

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

Children and families and contact with the outside world

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

6.1 Social visits had resumed in May 2021 and leaders had introduced appropriate infection-control measures that were sensible and minimised inconvenience for visiting families. The number of visits tables had been reduced from 28 to 20 to allow for social distancing; and prisoners and their family and friends had to take a lateral-flow test before the visit. This policy meant that prisoners could hold their children during the visit.

6.2 The crèche had been suspended as part of COVID restrictions. The kiosk was open to provide refreshments in the visits hall. When COVID outbreaks occurred and the kiosk had to close, snacks and drinks could be ordered in advance and were delivered to the visitor's table.

6.3 Leaders had continually improved the number of visits available and at the time of the inspection 740 visits slots could be booked each month, although only 287 of these had been used in the previous month. Under COVID restrictions, each wing had visits on a specific day; leaders believed that this had affected the number of visits that took place and were about to introduce a new timetable allowing greater flexibility. In our survey, 17% of prisoners said they had been able to see family and friends in person more than once in the last month, against the comparator of only 6%.

6.4 Secure video call visits (see Glossary) were well managed and it was very easy for prisoners to access them. They took place through laptop computers, which had been conveniently located on residential wings, and could be booked by the prisoner or their family to maximise sessions. There was no restriction on the number of video call visits a prisoner could have. Prisoners on E wing had the benefit of being able to use them until 7pm. The prison was funded to provide 433 such visits a month but the governor had voluntarily increased this to 1,200 There were 436 video call visits during November 2021.

6.5 Family days had recently restarted, which was rare in most similar prisons under COVID restrictions. There were two half-days in

December 2021, allowing 40 prisoners to spend additional time with their family and children. Food and activities were paid for by the family support provider and a local charity. Prisoners told us these were very positive events for both them and their families.

Reducing risk, rehabilitation and progression

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

6.6 Reducing reoffending work lacked clear direction and there was insufficient focus on sentence progression. The prison had undertaken a survey in late 2021 to capture the educational needs of the population, but there was no evidence of similar analysis of prisoners' needs in the other resettlement pathways, such as offending behaviour work. Since the previous inspection, the prison had stopped delivering accredited offending behaviour programmes and no prisoners had been released on temporary licence (ROTL) to support their resettlement during 2021. (See key concern and recommendation 1.43.)

6.7 Coldingley's resettlement policy described resettlement activities and a separate reducing reoffending action plan set out a list of high-level objectives that appeared reasonable for the population. However, many of the target lacked ambition and urgency with completion dates set for late 2022 or 2023, and there was little evidence that progress against the targets was being monitored. (See key concern and recommendation 1.43.)

6.8 Records of the monthly strategic reducing reoffending meeting indicated that the forum was used to share updates rather than providing an opportunity to drive a clear plan to improve rehabilitative outcomes. Committee members did not systematically or routinely assess all of the resettlement pathways or any resettlement data. Until the inspection, the head of reducing reoffending was not aware that their department did not collect data about prisoner employment on release.

6.9 Following the unification of probation services in 2021, the community rehabilitation company and all its staff had left the prison, and responsibility for resettlement planning reverted to the Probation Service. The senior probation officer had been instrumental in setting up temporary resettlement support from HMP Bronzefield. In addition to the reducing reoffending meeting, the prison held a monthly resettlement meeting. This forum provided good oversight of the support offered to prisoners on release and was well attended by a range of departments, including the offender management unit (OMU). However, this meeting took place near to the prisoner's release, which was sometimes too late to address resettlement needs that should

have started much earlier in their sentence - for example, rebuilding family ties or equipping prisoners with work skills relevant to their release area.

6.10 The OMU had been operating below the planned staffing level throughout much of 2021, which had contributed to significant backlogs of some important work, such as categorisation reviews and offender assessment system (OASys) reporting. New staff had recently been appointed, although there were still a few vacancies. This meant that some prison offender managers (POMs) had caseloads of around 70. They told us they were constantly under pressure to finish the next time-bound task, such as complete parole dossiers or conducting an OASys review. This left them with little capacity to factor in more regular contact with prisoners. The senior probation officer was also carrying a high caseload, which meant they were unable to fulfil key areas of their role, such as quality assurance of OASys assessments. There were arrangements for Probation Service colleagues in the community to assist with this, but we found examples where their work was not to the required standard.

6.11 The prison officer POMs were no longer cross-deployed to other duties. Due to staffing issues during 2021 and COVID restrictions, POMs had been given a modest target to contact prisoners on their caseload every three months. In the cases we saw, they were generally achieving this, and for high-risk prisoners, contact was usually more frequent. The use of P-Nomis (prison national offender management information system) to record contact was better than we have seen recently at other prisons, although it was often limited to completion of time-bound tasks, such as categorisation reviews. However, POMs told us they had little time to carry out one-to-one work with prisoners to progress their sentence plans. In our survey, 77% of respondents said they had a custody plan and more prisoners than the comparator (92% against 78%) said they understood their targets. However, only 49% said someone was helping them achieve these. (See key concern and recommendation 1.44.)

6.12 All POMs now received regular supervision from the senior probation officer, and a monthly team meeting included speakers from other departments to improve awareness of how departments could work together more effectively.

6.13 In our review of cases, over 40% of prisoners had not had a review of their OASys in the previous 12 months; 90 prisoners had not had a review in the previous two years and some had not been reviewed in three years. The senior probation officer was actively pursuing options to secure additional resources to reduce this backlog, but at the time of the inspection there was no clarity on when this might be achieved. We found several examples where the absence of an up-to-date OASys had delayed that prisoner's progression.

6.14 Most of the OASys sentence plans we reviewed were at least reasonably good. The majority of targets focused on areas such as getting a prison job, addressing substance misuse issues and

demonstrating positive behaviour. These were relevant and we saw examples of prisoners achieving them. However, there were few targets that required prisoners to address their offending behaviour, for example through specific programmes. POMs told us that the lack of programme delivery and the impracticality of delivering one-to-one work meant they were less likely to add specific offending behaviour targets than previously. In some of these cases, prisoners had not been able to demonstrate they had sufficiently reduced their risk of harm or reoffending to progress. (See key concern and recommendation 1.44.)

6.15 The prison held 95 indeterminate sentence prisoners. The previous lifer forums and family days remained suspended. We saw timely support for prisoners who were considered for parole, and during 2021 the board directed the release of seven indeterminate sentence prisoners and the transfer of four to open conditions. In 10 cases, the board directed the prisoner to remain in closed conditions, but the prison had not analysed the reasons to determine whether they indicated a lack of offending behaviour work.

6.16 The lack of offending behaviour work for all prisoners was compounded by the fact that key work was not operating as intended and had, in effect, become welfare checks (see paragraph 4.4). Prisoners did not have a consistent key worker with whom they could develop rapport and trust, and there was little evidence that officers conducting key work sessions had any knowledge of the prisoner's sentence plan objectives. Key workers did not routinely share information with POMs that might be relevant to that prisoner's progression, such as categorisation reviews, or information that might assist assessing their current risks (see recommendation 4.6).

6.17 Despite this, most of the risk management plans we saw were of reasonably good standard and we saw evidence of regular and effective contact between POMs and community offender managers (COMs) to discuss risk, such as those relating to public protection.

Recommendations

6.18 **Prisoners should have an up-to-date assessment of risk and need.**

6.19 **The lifer forum, information day and family visits should be resourced properly and take place regularly.**

Public protection

6.20 Arrangements for public protection were reasonable. All new arrivals received a screening to identify potential risks, which were added to a public protection database that could be accessed by relevant staff. Where there was information to indicate that the risk may still be current, an authorisation was sought to monitor that prisoner's mail or phone calls. Only two prisoners were currently subject to such arrangements; the authorisations were appropriate and monitoring was up to date.

6.21 The monthly inter-departmental risk management meeting had an appropriate focus on risk management planning for prisoners approaching release. The minutes highlighted regular information-sharing with COMs, although there was little evidence that the meeting shared information with departments other than the OMU.

6.22 The prison supported community partners involved in managing prisoners subject to multi-agency public protection arrangements (MAPPA). We saw evidence of POMs asking COMs to set MAPPA levels within appropriate timescales, although in a few cases the level had not been updated on the prisoner's record. The quality of reports prepared by POMs for MAPPA meetings was good and usually included a meaningful assessment of current risks.

Categorisation and transfers

6.23 Despite the lack of offending behaviour work in sentence plans, many prisoners were able to demonstrate that their risk of harm had reduced sufficiently to allow them to progress to open conditions. In the previous 12 months, 170 prisoners had transferred for this reason. However, despite active attempts by OMU staff to secure transport, some prisoners had to wait many months for a move. Prisoners who were waiting told us that the frustration of the delay was compounded by a lack of information about how long they might have to wait.

6.24 Some prisoners had experienced delays of several months before they even attained category D status as their OASys assessment was overdue for a review. We also found examples of prisoners who had been declined category D status as they had not completed offending behaviour programme work specified on their sentence plan.

Recommendation

6.25 **Prisoners should be moved promptly to category D prisons once they have been assessed as suitable for open conditions.**

Interventions

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

6.26 Since the previous inspection, Coldingley had stopped delivering any accredited offending behaviour programmes, and we were told that in the previous 12 months only one prisoner had been transferred to complete a programme elsewhere. The absence of such programmes and the lack of one-to-one work facilitated by POMs meant that in some of the cases we reviewed prisoners had lost an opportunity to reduce their risk of harm or risk of reoffending.

6.27 POMs had used the maturity screening assessment to identify younger prisoners who could benefit from the Choices and Changes

intervention (see Glossary); however, this had not yet been delivered to any prisoners.

6.28 Prisoners with substance misuse needs could access a range of interventions provided by Forward Trust including group and one-to-one work, and they could apply to live on the incentivised substance-free living unit (see paragraph 4.87).

6.29 There was some support for prisoners with employment needs. An information, advice and guidance (IAG) worker attended the prison three days a week to assist prisoners in obtaining the correct 'right to work' documents (National Insurance number and identity card). The IAG worker also helped prisoners develop a personal learning plan setting out their educational, training and employment needs, although over 40% of prisoners did not yet have such a plan. Prisoners did not have access to technology to search for or apply for jobs themselves. An employment broker from New Futures Network shared jobs from prospective employers, which had led to one offer of employment in the previous six months.

6.30 A Department for Work and Pensions (DWP) worker attended one day a week and offered benefits advice, as well as making advance appointments for prisoners to attend a benefits office on release to complete universal credit claims. Prison staff could open bank and credit union accounts on prisoners' behalf.

Release planning

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

6.31 There were about 10 releases a month into the community. About half were high-risk cases whose release plans were managed by their COM. These prisoners were often housed in approved premises as a condition of the licence.

6.32 Release planning for lower-risk cases was the responsibility of the POM and we saw good examples of casework to meet their needs on release, for example in securing accommodation. We did not see evidence of key workers contributing to resettlement planning.

6.33 In the previous 12 months, 39 prisoners had been released early on home detention curfew. This was reasonably well managed, although 23% of these were released late, mainly as a result of delays in the community, such as a lack of suitable accommodation.

6.34 The prison did not routinely collect data about accommodation on release and was unable to provide an accurate figure for how many prisoners were released without a suitable address in the previous 12 months. Minutes from the monthly resettlement meeting suggested that most prisoners had somewhere to stay on their day of release.

6.35 We did not find any evidence of resettlement plans recorded on prisoners' records. However, all impending releases were considered at the monthly resettlement meeting attended by a range of departments. Action taken was recorded in a database that highlighted that prisoners' needs on release had been met as far as possible.

Section 7 Recommendations in this report

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

Key concerns and recommendations

7.1 Key concern 1.34: In our survey, 38% of prisoners said drugs were easy to get hold of at the prison and most safety issues related to debt were associated with the use of illicit substances. Drug testing and aspects of searching were inadequate. The prison lacked an effective multidisciplinary strategy to reduce the supply of drugs and manage associated problems.

Recommendation: Leaders should develop a coordinated prison-wide strategy to detect and reduce the supply of illegal drugs and associated debt, bullying and violence.
(To the governor)

7.2 Key concern 1.35: The quality of some assessment, care in custody and teamwork (ACCT) casework management documents for at-risk prisoners was poor. Actions agreed at case reviews were not always identified on care plans, which left staff ill equipped to follow them through. The quality assurance system and subsequent action plan had not addressed the problem.

Recommendation: A robust quality assurance system should make sure that actions agreed at assessment, care in custody and teamwork (ACCT) reviews are clearly recorded on care plans and then completed by staff to help prisoners through their period of crisis.
(To the governor)

7.3 Key concern 1.36: Over half the prisoners lived on the older wings in poor conditions. The outdated sanitation system meant there were no toilets or running water in cells. Prisoners faced long waits to use the communal toilets, or were forced to use buckets in their cells with no facilities to wash their hands. Cells were cramped, dingy and cold, which was compounded by broken and moulding windows.

Recommendation: All prisoners should live in in suitable accommodation with reliable heating, a toilet and hand washing facilities.
(To the governor)

7.4 Key concern 1.37: Work to ensure equality at the prison had not been prioritised during the pandemic. Leaders did not monitor disproportionality, the equality action plan had been closed and consultation with prisoners with protected characteristics was very limited.

Recommendation: There should be effective consultation and monitoring to make sure that the needs of prisoners with protected characteristics are identified and met, and that disproportionate outcomes are addressed.
(To the governor)

7.5 Key concern 1.38: Psychological therapy provision did not meet patient need, with staff shortages resulting in approximately 40 waiting for their treatment to start, some for many months.

Recommendation: Patients diagnosed with a need for psychological therapy should be treated promptly.
(To the governor)

7.6 Key concern 1.39: Leaders and managers had not considered the quality of teaching and assessment, the appropriateness of the content of learning programmes or how effectively education and training courses were designed. No effective action had been taken to make sure that the quality of education, skills and work improved, and too many prisoners were not successful in their learning.

Recommendation: Leaders should identify accurate areas for improvement in teaching and assessment practices, and in curriculum design and content. They should also identify and implement actions to make sure that teachers and instructors improve their skills in teaching, and enable prisoners to build on, and make progress in, developing their skills and knowledge.
(To the governor)

7.7 Key concern 1.40: A high proportion of prisoners chose not to attend their allocated education, skills or work activity, and too many remained unemployed and not engaged in any purposeful activity.

Recommendation: Leaders and managers should ascertain the reasons why prisoners do not wish to engage in education and work, and take effective action to improve attendance and the proportion of prisoners allocated to appropriate activities. Prison staff should consistently promote the benefits of education to prisoners in their rehabilitation and future employability.
(To the governor)

7.8 Key concern 1.41: The prison induction did not provide prisoners with useful information about their options for activities at the prison and to make informed and appropriate choices. Prisoners did not receive impartial careers advice and guidance to establish their aspirations or help make suitable choices about future employment.

Recommendation: Information about prisoners' aspirations and long-term employment goals should be used to inform allocations to education, skills and work activities, and they should receive impartial advice and guidance that promotes career development.

(To the governor)

7.9 Key concern 1.42: There was no effective oversight of education, skills and work and the quality of prison-led activities was not monitored. Most prisoners in prison-led workshops were not challenged by their work roles and instructors did not help them to learn new skills. The progress that prisoners made in these areas was not recognised or recorded effectively, and too few prison-led activities resulted in accreditation.

Recommendation: The quality of prison-led activities should be monitored. Prisoners should be sufficiently challenged in all workshops, instructors should recognise and record the progress they make, and the number of accredited programmes in prison-led activities and prisoners who achieve these should be increased.
(To the governor).

7.10 Key concern 1.43: The prison lacked an adequate needs analysis to clearly identify the resettlement needs of the population. The reducing reoffending strategy and associated meeting did not identify and drive actions to make sure that support was available across all pathways. There was no evidence that data were used to monitor and improve outcomes.

Recommendation: Leaders should identify and understand the resettlement needs of the population and make sure that interventions and services are provided to meet those needs.
(To the governor)

7.11 Key concern 1.44: There was insufficient focus on, and opportunities for, sentence progression by prisoners. Coldingley had stopped delivering accredited offending behaviour programmes and prisoners were not transferred to complete these elsewhere. There was little one-to-one offending behaviour work with prisoners, and sentence plans often failed to identify specific offending behaviour targets. Some prisoners had not reduced their risk of harm or reoffending sufficiently before release.

Recommendation: Prisoners' offending behaviour needs should be identified and met to reduce their risk of reoffending on release.
(To the governor)

Recommendations

7.12 Recommendation 3.26: Use of force scrutiny meetings should fully analyse the data presented to monitor trends, identify good practice and learn lessons.
(To the governor)

7.13 Recommendation 4.5: Effective staff supervision in all residential areas should enable staff to detect and challenge low-level poor behaviour.
(To the governor)

7.14 Recommendation 4.6: Prisoners should be supported by a named keyworker to support their well-being and sentence progression.
(To the governor)

7.15 Recommendation 4.28: Responses to prisoner complaints should be prompt and fully address the issues raised.
(To the governor)

7.16 Recommendation 4.29: The prison should track prisoners' application forms so that leaders are clear about the nature of the problem, promptness and quality of responses.
(To the governor)

7.17 Recommendation 4.55: Patients should be able to make a confidential complaint or application for a health care appointment.
(To the governor)

7.18 Recommendation 4.56: All patient care should be recorded on SystmOne to maintain the integrity of a single clinical record.
(To the governor)

7.19 Recommendation 4.67: Patient access to external appointments, assessment and treatment should not be delayed by the lack of escorts.
(To the governor)

7.20 Recommendation 6.18: Prisoners should have an up-to-date assessment of risk and need.
(To the governor)

7.21 Recommendation 6.19: The lifer forum, information day and family visits should be resourced properly and take place regularly.
(To the governor)

7.22 Recommendation 6.25: Prisoners should be moved promptly to category D prisons once they have been assessed as suitable for open conditions.
(To the governor)

Section 8 Progress on recommendations from the last full inspection

Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy prison. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2017, prisoners were generally positive about escorts to the prison. Early days support was good. More prisoners felt unsafe than at our previous inspection. Levels of violence were not comparably high but had increased. Care for those vulnerable to self-harm was generally good. Security arrangements were mainly appropriate. A more strategic approach to drug use and associated debt was required and the drug strategy and testing needed attention. Adjudication processes were fair. Use of force was not high and generally proportionate. Some men were isolating themselves and often ended up in segregation. Substance misuse support was generally good. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendation

The prison should introduce a more strategic response to the problems of illegal drug supply and use and associated debt, bullying and violence. (S39)
Not achieved

Recommendations

The prison should implement an effective strategy to reduce violence. (1.13)
Not achieved

A range of interventions should be used to challenge and manage perpetrators of violence and to support victims of violence. (1.14)
Not achieved

Quality assurance for ACCT documents should ensure plans are effective and interactions appropriate. (1.21)
Not achieved

The prison should ensure that effective links are established with the Surrey adult safeguarding board and that staff are aware of their adult safeguarding responsibilities. (1.23)
Achieved

Managers should routinely analyse use of force data and review incidents to monitor trends, identify good practice and learn lessons. (1.33)
Not achieved

Care plans should be raised for all prisoners relocating to the segregation unit for their own protection, with an emphasis on reintegrating them to mainstream location. (1.38, repeated recommendation 1.68)
Not achieved

All prisoners in the segregation unit should receive at least one hour in the open air every day. (1.39, repeated recommendation 1.69)
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2017, the night sanitation system remained degrading and the older units were poor. Staff-prisoner relationships were reasonable. Some aspects of equality and diversity work were underdeveloped and needed to be re-launched. Faith provision was good and complaints were well managed. Prisoners felt their legal rights were respected. Health care was good and many prisoners valued it. Food was relatively good, but the kitchen was in poor condition. Canteen arrangements were reasonable. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

The refurbishment of wings A to D and F should be comprehensive and include recess areas, windows and the kitchen. The night time sanitation should work properly and, long term, it should be replaced as a matter of priority. (S40)
Not achieved

The prison should ensure the needs of men with protected characteristics are understood and identify any concerns they have about fair and equitable treatment; where possible these needs should be met and concerns addressed. (S41)
Not achieved

Recommendations

The cleanliness and day-to-day maintenance of wings A to D should be improved to ensure the men live in as decent conditions as possible. (2.8)
Achieved

Equalities monitoring should be robust, consistent and used to determine trends over time. (2.17)
Not achieved

Responses to DIRFs should be timely, detailed and demonstrate that a thorough investigation had taken place. (2.18)
Not achieved

Wing staff should be familiar with the needs of prisoners who have a PEEP. (2.25)
Achieved

Legal visits should be private. (2.34)
Achieved

All custody staff should receive regular basic life support training as part of their mandatory training programme and AEDs should be located on all wings. (2.46)
Achieved

Prisoners should be able to complain about health services through a well-publicised, confidential system; responses should address the issues raised in full and prisoners should receive information on how to escalate their complaint if they are dissatisfied with the response. (2.47)
Partially achieved

An adequate range of PGDs should be available so minor ailments can be treated without a prescription. (2.58)
Achieved

All prisoners should have timely access to dental services. (2.62, repeated recommendation 2.81)
Achieved

The dental environment should comply with infection prevention standards and the damaged plasterwork in the treatment room should be repaired. (2.63)
Achieved

Prisoners, especially those on longer sentences, should be able to cater for themselves. (2.74)
Achieved

The kitchen and surrounding areas should be kept clean. (2.75)
Achieved

The prison should identify why black and minority ethnic and Muslim prisoners have poorer perceptions of the food and range of products in the shop and address them. (2.77)
Not achieved

Purposeful activity

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

At the last inspection, in 2017, prisoners' time out of their cells was very good. Leadership of learning, skills and work was effective but management needed to make better use of data to further improve achievements. There were sufficient activity places for the population and most men had purposeful and productive work to do, although more work could have been accredited and offered at higher levels. Attendance required improvement and the induction process needed development. The quality of teaching and learning was good, and achievements were generally good other than in English and maths. Behaviour in activities was generally good and men were encouraged to work well together and develop useful skills. The library had improved considerably and the gym was good. Outcomes for prisoners were reasonably good against this healthy prison test.

Recommendations

Senior managers should ensure all prisoners regularly attend planned education activities, particularly English and maths lessons. (3.11)
Not achieved

Managers should analyse information in detail and use it to identify examples of best practice and areas for improvement and to agree measurable outcomes for subsequent actions. (3.12)
Not achieved

The education and training provision should be extended to include higher level learning. (3.18)
Not achieved

There should be a greater number and range of work-related and vocational courses. (3.19)
Not achieved

Teachers and instructors should make better use of the induction period to carry out a detailed initial assessment of prisoners' skills and prior educational attainment to better inform their planning of learning and work activities. (3.26)
Partially achieved

Senior managers should take action to drive up achievement rates on English and maths courses. (3.34)
Not achieved

Prisoners should be able to use an appropriate outdoor sports field. (3.43, repeated recommendation 3.46)
Not achieved

Resettlement

Prisoners are prepared for their release back into the community and effectively helped to reduce the likelihood of reoffending.

At the last inspection, in 2017, the prison understood men's resettlement needs. Many long-term prisoners felt they could make progress. A range of appropriate interventions were offered, but some resettlement work required better coordination. Offender management work was appropriately prioritised and was reasonably good overall, and more prisoners than usual felt well supported. Public protection arrangements were generally appropriate. Categorisation work was good overall. Most men progressed to other prisons, but support for those released met most prisoners' needs and more men than usual said they had done something at Coldingley to make it less likely they would offend in the future. Children and families work was reasonable. An appropriate range of offending behaviour courses were offered. Outcomes for prisoners were good against this healthy prison test.

Recommendations

Contact between offender supervisors and prisoners on their caseload should be consistent and ensure men are supported in achieving their targets. (4.13)
Not achieved

All offender supervisors should receive case management supervision. (4.14)
Achieved

The lifer forum, information day and family visits should be resourced properly and take place regularly. (4.25)
Not achieved

Catch 22 and departments within the prison should systematically share and record data about post-release outcomes. (4.28)
Not achieved

Services should be promoted more actively and resettlement planning should be improved. (4.29)
Not achieved

The visitors' centre should be developed to provide visitors with an appropriate service. (4.43, repeated recommendation 4.46)
Not achieved

Visitors should be admitted to the visits room punctually to allow a full two-hour visit. (4.44, repeated recommendation 4.44)
Not achieved

All relevant prison staff should undertake safeguarding children training. (4.45)
Not achieved

The £15 charge for family days should be abolished. (4.46)
Achieved

Appendix I About our inspections and reports

Her Majesty's Inspectorate of Prisons is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

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

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

Respect
Prisoners are treated with respect for their human dignity.

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

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

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

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

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

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

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

Our assessments might result in one of the following:

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

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

Examples of notable positive practice: innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

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

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

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

This report

This report provides a summary of our inspection findings against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 5, 2017) (available on

our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/). The reference numbers at the end of some recommendations indicate that they are repeated and provide the paragraph location of the previous recommendation in the last report. Section 7 lists all recommendations made in the report. Section 8 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

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

Inspection team

This inspection was carried out by:

Martin Lomas	Deputy chief inspector
Deborah Butler	Team leader
Ian Dickens	Inspector
Martyn Griffiths	Inspector
Sumayyah Hassam	Inspector
Lindsay Jones	Inspector
David Owens	Inspector
Esra Sari	Inspector
Nadia Syed	Inspector
Elenor Ben-Ari	Researcher
Annie Bunce	Researcher
Rachel Duncan	Researcher
Amilcar Johnson	Researcher
Sarah Goodwin	Lead health and social care inspector
Tania Osborne	Health and social care inspector
Karen Wilson	Health and social care inspector
Dayni Johnson	Care Quality Commission inspector
Carolyn Brownsea	Ofsted inspector
Rieks Drijver	Ofsted inspector
Rebecca Perry	Ofsted inspector
Gayle Saundry	Ofsted inspector
Jai Sharda	Ofsted inspector

Appendix II Glossary

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

Aerosol generating procedures (AGPs)
Certain medical and patient care activities that can result in the release of airborne particles (aerosols), and a risk of airborne-transmission of infections that are usually only spread by droplet transmission.

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

Certified normal accommodation (CNA) and operational capacity
Baseline CNA is the sum total of all certified accommodation in an establishment except cells in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged cells, cells affected by building works, and cells taken out of use due to staff shortages. Operational capacity is the total number of prisoners that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

Challenge, support and intervention plan (CSIP)
Used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence.

Choices and Changes
An HMPPS resource pack for key workers or prison offender managers to use in one-to-one sessions with young adults identified as having low psychosocial maturity. It aims to encourage engagement and help young adults to develop their maturity.

Key worker scheme
The key worker scheme operates across the closed male estate and is one element of the Offender Management in Custody (OMiC) model. All prison officers have a caseload of around six prisoners. The aim is to enable staff to develop constructive, motivational relationships with prisoners, which can support and encourage them to work towards positive rehabilitative goals.

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

Night sanitation
An electronic system for prisoners in cells without toilets or running water to be unlocked to access a toilet individually through the night.

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

Protection of adults at risk
Safeguarding duties apply to an adult who:

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

Recovery plan
Recovery plans are published by HMPPS and aim to ensure consistency in decision-making by governors, by setting out the requirements that must be met for prisons to move from the most restricted regime (4) to the least (1) as they ease COVID-19 restrictions.

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

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

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

Appendix III Care Quality Commission Requirement Notice

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

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

Requirement Notices

Provider Central and North West London NHS Foundation Trust

Location Trust Headquarters, 350 Euston Road (HMP Coldingley)

Location ID RV3X2

Regulated activities

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

Action we have told the provider to take

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

Regulation 9 (1)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014)

Regulation 9: Person centred care (1)(b) The care and treatment of service users must meet their needs.

How the regulation was not being met

There were gaps in psychological therapy provision which resulted in unmet patient need. As a result of staff shortages approximately 40 patients, who had been assessed and accepted for psychological therapy, were waiting for their

treatment to start. Seventeen of these patients had waited for over three months for their therapy, with one patient waiting for 13 months. A further 15 patients were awaiting an assessment for psychological therapy. This meant that the needs of service users were not being met.

Appendix IV Further resources

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

Prison population profile

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

Prisoner survey methodology and results

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

Prison staff survey

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

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