Report on an unannounced inspection of

HMP Elmley

by HM Chief Inspector of Prisons

28 February–1 March and 7–11 March 2022

Contents

Introduction

HMP Elmley is a Category B reception and category C training prison located on the Isle of Sheppey. The category C prisoners, which made up 45% of the population, were housed on a separate wing.

The relationships between staff and prisoners were better than we usually see in this sort of prison and during the inspection we were impressed by the way most officers interacted with the men. In spite of ongoing COVID-19 cases in prisoners arriving at the jail, the prison had worked hard to keep the regime going and those in work were out of their cells for more than seven hours a day. Even unemployed prisoners could expect to be unlocked for at least five hours. It was therefore disappointing that the provision of education was so poor, with Ofsted inspectors awarding their lowest grade in two areas and their second lowest in two more, with the quality of teaching and the lack of a proper needs assessment being particularly disappointing.

The governor, who was well-liked by both staff and prisoners, had only been in post since August 2021, but she had made some progress in building a more rehabilitative culture as the risk from COVID-19 began to recede.

Levels of violence were slightly below the average for similar prisons, although prisoners' perception of their own safety had not improved since our last inspection. In spite of this, the use of force had gone up significantly and the leaders had not done enough to understand the reasons for this rise. The processes for assessing, addressing and monitoring the behaviour of the more serious perpetrators of violence was not yet effective enough. We were concerned that at Elmley, a much larger number of incidents than we usually see were routinely being classed as "miscellaneous" rather than being put in a more suitable category. We also found that the use of data in measuring outcomes between different groups was not sophisticated enough to understand and act where these were disproportionate.

We were disappointed to hear that the excellent early days mental health screening pilot was coming to an end. This had aimed to identify those prisoners whose mental health was at risk and was valued by both prisoners and staff. We were assured that the new service model would incorporate the same level of service and support. In health care more generally, there were not enough staff members to be able to provide a stable, high-quality service, leading to delays and a lack of consistency.

The prison received more complaints than any other local prison, to which its responses were often neither timely nor helpful. This is partly because the system for making applications was not working, leading to greater prisoner frustration.

We were very pleased to see that the prison was offering visits every day of the week. This was much better than we often see in other jails, where COVID-19 restrictions or staffing shortages tend to result in provision being curtailed.

Staffing levels at the prison have deteriorated in recent months, but they are not yet at a critical level. The way staff are deployed is not always as creative as it could be. Consequently, key work has largely been lost and prisoner offender managers (POM) in the offender management unit are often cross deployed, directly affecting prisoner progression.

There is much to build on at Elmley with many good staff members and a leadership team that has grown in confidence. The prison will need to continue to be led effectively and creatively if it is to build on the findings of this inspection.

Charlie Taylor
HM Chief Inspector of Prisons
April 2022

About HMP Elmley

Task of the prison/establishment
Category B reception and category C training prison for adult males.

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 1,095
Baseline certified normal capacity: 1,007
In-use certified normal capacity: 1,007
Operational capacity: 1,137

Population of the prison
- 2,793 new prisoners received each year (around 232 per month).
- 194 foreign national prisoners (18%).
- 19.8% of prisoners from black and minority ethnic backgrounds.
- 129 prisoners released into the community each month.
- Around 38% of the population were known to the substance misuse service.
- 350 prisoners referred for mental health assessment each month.

Prison status (public or private) and key providers
Public

Physical health provider: Integrated Care 24
Mental health provider: Oxleas NHS Foundation Trust
Substance misuse treatment provider: Forward Trust
Prison education framework provider: Weston College
Escort contractor: Serco

Prison group
Kent, Surrey and Sussex

Brief history
Elmley opened in 1992 and is the largest of the three prisons on the Isle of Sheppey. Since the 2019 inspection it has changed its role; while its primary function is to receive remand prisoners from the courts, its secondary purpose is now as a training establishment for a large population of sentenced category C prisoners (almost 500 currently).

Short description of residential units
House block 1 first night and induction, currently also operating as reverse cohort unit (see Glossary)
House block 2 remand and convicted prisoners
House block 3 substance recovery, working in partnership with Forward Trust
House block 4 remand and convicted prisoners
House block 5 enhanced and category C prisoners and full-time workers
House block 6 foreign nationals and sex offenders.

Planning permission has recently been granted for house block 7.

Name of governor and date in post
Dawn Mauldon, 8 August 2021

Leadership changes since the last inspection
Paul Woods, governor, November 2018–August 2021

Prison Group Director
Susan Howard

Independent Monitoring Board chairs
Pam Spindlow, John Cunningham

Date of last inspection
23–24 April, 19 April–3 May 2019

Section 1 Summary of key findings

1.1 We last inspected HMP Elmley in 2019 and made 31 recommendations, 11 of which were about areas of key concern. The prison fully accepted 27 of the recommendations and partially (or subject to resources) accepted four.

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 Elmley 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 two recommendations about key concerns in the area of safety. At this inspection we found that one of those recommendations had been achieved and one had not been achieved.

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

1.6 We made one recommendation about key concerns in the area of purposeful activity. At this inspection we found that this recommendation had been partially achieved.

1.7 We made four recommendations about key concerns in the area of rehabilitation and release planning. At this inspection we found that all four of these recommendations had not been achieved.

Outcomes for prisoners

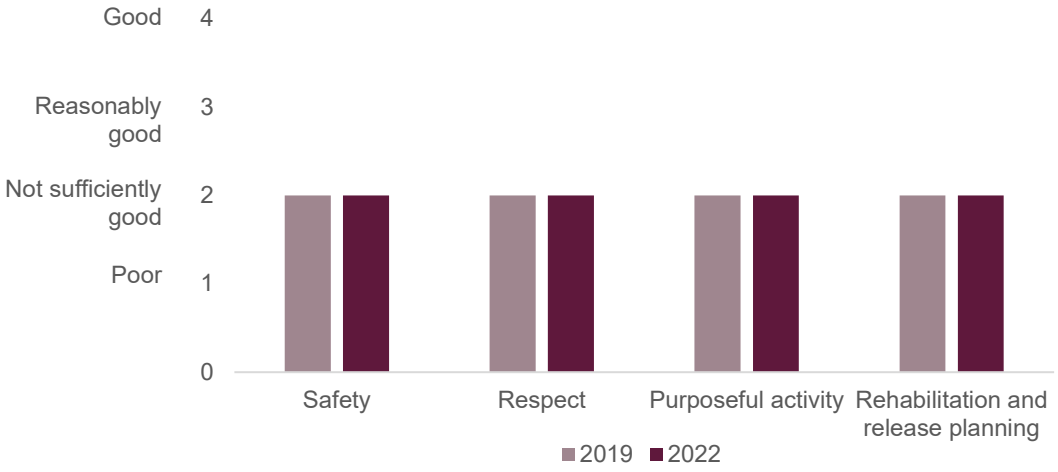
1.8 We assess outcomes for prisoners against four healthy prison tests (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.9 At this inspection of Elmley, we found that outcomes for prisoners had stayed the same in all four healthy prison areas.

1.10 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 Elmley healthy prison outcomes 2019 and 2022



Safety

At the last inspection of Elmley in 2019 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

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

1.11 Reception was a busy environment. New arrivals were treated well and the process was relatively swift. First night cells were unwelcoming and some new prisoners missed important aspects of induction.

1.12 One in four prisoners in our survey said they currently felt unsafe. Prisoner-on-prisoner violence had decreased but levels of violence against staff and serious assaults were broadly comparable to the last inspection. Not all violent incidents were investigated, which meant that leaders were unable to fully understand the causes and drivers of violence at Elmley.

1.13 There were weaknesses in the systems to address violence and behaviour issues, including challenge, support and intervention plans (CSIPs, see Glossary), the Incentives Policy and adjudications. In addition, serious cases referred to the police were not progressed and had a limited deterrent effect. There was little distinction between what was offered on the house blocks, which meant that the category C enhanced spur was not effective as a tool to motivate good behaviour and encourage progression.

1.14 The use of force had increased since the last inspection, even though prisoners were locked up for longer and so spent less time in contact with others. The incidents of force we were able to review demonstrated some good de-escalation by staff, but too many,

including serious incidents involving batons or PAVA incapacitant spray, were not recorded on body-worn video cameras. Investigations into the use of force were not always thorough so it was difficult to be assured that it had been reasonable and proportionate.

1.15 Segregation to manage the most challenging prisoners was used proportionately. Relationships between officers and prisoners on the unit were good and prisoners had good access to mental health staff. The cells were hot and not always sufficiently clean, and until recently prisoners could not shower every day. Reasonable reintegration planning made sure that prisoners were not segregated for too long.

1.16 Security arrangements were proportionate. Intelligence reports were of reasonable quality, but staff redeployment had reduced the department's ability to respond. Too many incident reports were recorded as 'miscellaneous', rather than ascribed to specific indicators of security breaches, which left the prison poorly placed to understand the full extent of problems relating to safety. The strategic approach to drug supply reduction had greatly improved.

1.17 There had been four self-inflicted deaths since our last visit. The prison had begun implementing recommendations from the two Prisons and Probation Ombudsman (PPO) investigation reports received to date, but implementation was not monitored over time to ensure ongoing compliance. Reported self-harm was lower than in most comparable prisons but had increased since our last visit and was on an upward trend. Data analysis of self-harm was poor. The safer custody team was well resourced and had recently introduced some good initiatives and safeguards to identify and support prisoners at risk. Prisoners supported through assessment, care in custody and teamwork (ACCT) case management were generally positive about the care they received, although there were some weaknesses in the process itself. There was an action plan to improve the quality of case management. The prison operated an effective Listener scheme (see Glossary) to provide peer support to those in need.

Respect

At the last inspection of Elmley in 2019 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

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

1.18 The majority of staff were visible and approachable. In our survey, prisoners were more positive about staff relationships than in similar prisons. However, there was too little key work to develop relationships and make them more constructive. Peer work was established, but there were opportunities to develop this to greater effect.

1.19 Around 30% of prisoners lived in overcrowded conditions, with two occupying cells designed for one. These were often untidy and not

adequately equipped, but the prison had begun to address this. Although some showers had been refurbished to a good standard, many remained grubby and lacked sufficient privacy. Prisoners had good access to clean clothing and bedding each week.

1.20 Despite efforts to improve the food, many prisoners complained about the quality and size of meals. The prison shop catered for most prisoner needs, but there were also many valid complaints relating to missing items and problems receiving refunds.

1.21 The Elmley community consultation group met regularly but was not yet fully effective, and many prisoners were unsure if consultation had led to improvement. There were weaknesses in the application system and, despite improvements, responses to prisoner complaints did not always address the issue fully; some had waited months for a response.

1.22 Monthly diversity and inclusion meetings provided a focus for equality work and were attended by prisoner representatives. The meetings examined data and leaders had compiled an action plan to address some identified shortfalls. However, in the absence of a needs analysis and clear strategy setting out the main objectives, it was difficult to monitor outcomes or assess progress in equality and diversity work.

1.23 There were inconsistencies in the focus and support given to prisoners with protected characteristics. For example, consultation with prisoners from some, but not all, protected groups had recently restarted, and senior managers had been appointed as leads for most groups. However, there had been no consultation with prisoners with disabilities and no senior lead appointed to ensure appropriate support for foreign national prisoners. It was too early to assess the impact of some recent initiatives to address the needs of protected groups.

1.24 A dedicated and well-managed chaplaincy provided important pastoral support and care, particularly for prisoners in crisis. While opportunities for corporate worship remained too limited, prisoners greatly valued the multi-faith team.

1.25 Many prisoners expressed frustration about access to health care, another department that had experienced notable staff shortages during the pandemic. The primary care service had prioritised essential services and was now running clinics on the wings where possible. GPs were covering gaps in the provision, which had extended waits for routine GP appointments to four weeks, which was too long. A range of allied health professionals and external services were providing clinics, but prisoner attendance was variable due to factors such as lack of officer escorts. Attendance at external hospital appointments was also affected by prison arrangements for hospital escorts and long delays in access to community provision. The inpatient department provided good care for patients with complex mental health needs. Social care was good, including continuity of care on release.

1.26 Against a background of significant workforce challenges, mental health services had responded positively to prisoners in need of urgent support. Prisoners waited longer than before the pandemic to access routine psychological care, but caring staff provided alternative support while they waited. Support for prisoners with substance misuse needs was reasonably good.

1.27 Most aspects of pharmacy services were adequate, although inconsistent officer supervision of medicine queues increased the risk of medicines being diverted. Dental services were good with waits for routine appointments reduced to four weeks.

Purposeful activity

At the last inspection of Elmley in 2019 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

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

1.28 The new, less restricted regime had increased prisoner time out of cell to up to seven hours on a weekday for the few prisoners working full time. During our roll checks we found one-third of prisoners locked behind their doors which, although still too many, was better than in similar prisons. Only half of those prisoners who were unlocked were actually in education or work. Prisoners on the house block 5 enhanced spur benefited from evening association, which meant they had up to nine hours a day out of cell, which was good. At weekends, most prisoners were unlocked for only three hours a day.

1.29 After a long period of closure, prisoners could now visit a well-stocked, welcoming library twice a week. This was also complemented by an outreach service. PE facilities were very good, including a large sports hall, well-equipped gym and weights annex. Monitoring of attendance data was limited, leaving the prison poorly equipped to target non-attenders and encourage wider participation.

1.30 Leaders and managers had correctly identified weaknesses in the education provision, but the overall quality of education, particularly in classroom-based subjects, was inadequate. Recent actions to address this had not yet had the necessary impact.

1.31 Too few prisoners attended the education, skills, and work activities they were assigned to. The induction sessions offered by the learning and skills provider did not motivate prisoners to attend activities or provide sufficient information about the options on offer. Teachers did not focus closely enough on what prisoners most needed to learn and did not do enough to support those with learning difficulties or disabilities.

1.32 Teachers did not provide targeted feedback that supported prisoners to progress in their learning, and too few achieved the qualification they

were working towards. Prisoners did not receive sufficient careers advice and guidance. The use of data was weak, and leaders did not adequately track trends in recruitment, retention and achievement on education courses.

1.33 Leaders offered a suitable range of provision to prisoners. Behaviour was good and prisoners valued their education and work activities. Support from the new employer adviser had steadily increased the number of prisoners going into work. Leaders made sure that the curriculum included valuable programmes, such as music, mindfulness and art, which enabled some prisoners to make progress with their mental health.

Rehabilitation and release planning

At the last inspection of Elmley in 2019 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

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

1.34 Prisoners had better opportunities to have in-person social visits than we had seen at most other prisons since the start of the pandemic. The Spurgeons charity provided some good family initiatives that prisoners greatly appreciated. All prisoners had in-cell telephones, enabling them to maintain contact with families.

1.35 A recently revised strategy and improvements to governance arrangements to coordinate better reducing reoffending work looked positive. In addition to its primary function serving the courts, Elmley was now also a training prison for the 40% of sentenced prisoners who were category C. There was little distinction between the prison's category B and category C functions, with too few opportunities for category C prisoners to demonstrate a reduction in risk or progress through their sentence.

1.36 Prison officer in prison offender managers (POM) roles were still cross-deployed to other duties too often, which affected their ability to maintain regular contact with prisoners on their caseload. There was still a backlog of prisoner assessments (OASys) to be completed, and some of the sentence plans we reviewed were not good enough to support sentence progression. There were weaknesses in the administration of home detention curfew.

1.37 Public protection arrangements remained inadequate. The interdepartmental risk management team meeting focused only on prisoners on the higher levels of multi-agency public protection arrangements (MAPPA) and missed the opportunity to manage the risks of some other high-risk prisoners. Delays in the monitoring of phone calls made by prisoners identified as posing a risk to the public was a concern.

1.38 COVID restrictions and staff shortages had severely affected the delivery of interventions to address offending behaviour. Prisoners had benefited from the support of the new employment adviser under the 'Accelerator' pilot (see Glossary), which had already led to employment for a small number of prisoners on release. The scheme also provided an accommodation adviser. But despite concerted efforts by prison staff to secure accommodation, many prisoners were discharged from Elmley without an address to go to.

1.39 The resettlement team assessed the resettlement needs of all new arrivals and then reviewed all low- and medium-risk prisoners 12 weeks before release to help them with their release plan. The weekly resettlement meeting provided assurance that action was being taken to support those being released.

Key concerns and recommendations

1.40 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.

1.41 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.

1.42 Key concern: Systems to understand and respond to the causes of violence were underdeveloped. Not all violent incidents were investigated and there was little evidence that lessons were learned from those that were. In the sample of investigations we reviewed, there was usually a lack of inquiry into why the incident happened and how it could have been prevented.

Recommendation: Investigations into incidents of violence should be sufficiently thorough to understand and respond to the causes of violence, ensuring that perpetrators and victims are managed and supported appropriately.
(To the governor)

1.43 Key concern: Use of force documentation was not always fully completed and, although body-worn video cameras were readily available, too many staff failed to activate them during an incident to provide evidence and support de-escalation.

Recommendation: Leaders should make sure that staff routinely switch on body-worn cameras during use of force incidents, and there is proper oversight of documentation
(To the governor)

1.44 Key concern: There were weaknesses in the governance of adjudications, segregation and security. Records of the key meetings providing scrutiny in these areas did not give assurance that important issues were discussed or that the right people were in attendance. Poor assessment of data undermined the prison's understanding of some of the challenges it faced.

Recommendation: There should be effective oversight of all aspects of safety in the prison. Governance meetings should be well attended, and discussion and action should focus on key priorities in each area informed by good data analysis.
(To the governor)

1.45 Key concern: The absence of a needs analysis and clearly defined equality strategy left leaders without a sense of direction or the ability to monitor progress or assess outcomes for prisoners with protected characteristics. There was little evidence that the needs of these prisoners were understood or met. Recent consultation with protected groups lacked purpose, direction and focus.

Recommendation: The prison should have a clear strategy to identify and meet the needs of prisoners from all protected characteristic groups, ensuring there is no disproportionate treatment. (Repeated key recommendation S39.)
(To the governor)

1.46 Key Concern: Staffing shortages in primary health care had led to weaknesses in governance, a reduction in the services available and long waiting times. Staffing shortfalls across the prison also affected prisoner access to internal and external health appointments.

Recommendation: Staffing levels should be sufficient to ensure that prisoners have timely access to the full range of primary health services and appointments.
(To the governor and the health provider)

1.47 Key concern: Prisoners received a low quality of education, particularly in classroom and outreach settings. They did not develop substantial new knowledge and skills, and they achieved accredited qualifications at low rates.

Recommendation: Leaders should take rapid action to address the poor quality of teaching in classroom-based education, for example through improved training and quality assurance. They should make sure that prisoners have opportunities to develop substantial new knowledge and skills and, as a result, to achieve accredited qualifications at high rates.
(To the governor)

1.48 Key concern: Leaders did not use data effectively to monitor the quality of education. For example, they did not adequately track trends in recruitment, retention and achievement, and use this information to

tackle weaknesses in the education provision.

Recommendation: Leaders should make more effective use of data to scrutinise the performance of learners on education courses.
(To the governor)

1.49 Key concern: Prisoners did not receive a thorough induction to education, skills and work or enough information about their education, skills and work options. Staff inhibited prisoners from making choices by discussing their confidential information in front of other prisoners. Leaders did not make sure that allocations to activities matched prisoners' career goals.

Recommendation: Leaders should make sure that prisoners benefit from a good-quality induction, carried out sensitively, that helps them to make informed choices about their work or study options, and that allocations to courses match prisoners' career aspirations.
(To the governor)

1.50 Key concern: Prisoners with learning difficulties and/or disabilities received inadequate support and support plans did not identify appropriate strategies. Prisoners who required a more in-depth assessment of their needs had to wait too long for an assessment. Too many teachers lacked the confidence to support prisoners with learning difficulties and/or disabilities effectively.

Recommendation: Leaders should make sure that prisoners with learning difficulties and/or disabilities needs receive appropriate support that enables them to make good progress in education, skills and work activities.
(To the governor)

1.51 Key concern: There was insufficient focus on, and opportunities for, sentence progression by prisoners. Contact between prison offender managers and prisoners was too infrequent, and many of the targets in prisoners' sentence plans were not specific about the work they needed to do to reduce their risk. Very few prisoners had been able to complete accredited offending behaviour programmes at Elmley or elsewhere, and POMs did not undertake one-to-one offending behaviour work with prisoners.

Recommendation: Prisoners should be able to access appropriate offending behaviour interventions to reduce their risk and progress through their sentence.
(To the governor)

1.52 Key concern: Public protection arrangements were inadequate. The scope of the inter-departmental risk management meeting was too limited to consider all high-risk prisoners approaching release. There was a six-week backlog of phone calls made by high-risk prisoners waiting to be monitored.

Recommendation: Leaders should enforce robust arrangements to protect the public by identifying and managing effectively the risks posed by all high-risk prisoners in custody and before their release.
(To the governor)

Notable positive practice

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

1.54 Inspectors found three examples of notable positive practice during this inspection.

1.55 Segregation reviews were multidisciplinary and could involve the prisoner's family. In one case, the mother of a prisoner was invited to a review to help staff understand his needs better. (See paragraph 3.27.)

1.56 A nurse-led multidisciplinary chronic pain clinic helped patients to manage and overcome the challenge of suffering with long-term pain. This positive approach to pain management meant that patients received a comprehensive service to help them cope in the most effective way. (See paragraph 4.59.)

1.57 The social care team was compassionate and provided exemplary care and support to prisoners with an identified social care need. Continuity of care was achieved by well-organised and effective pathways, including the smooth transition of released prisoners into community nursing/residential homes. (See paragraphs 4.63 - 4.66.)

Section 2 Leadership

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

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

2.2 The impact of national restrictions in response to the COVID-19 pandemic had presented the prison with major challenges over the last two years. Leaders had worked successfully with health care providers and the UK Health Security Agency to manage several COVID outbreaks.

2.3 The priorities described in the self-assessment report were broadly in line with those we identified during our inspection. Managers were more familiar with the priorities than frontline staff, although both identified the importance of regime recovery and improving safety. We urged caution about leaders' optimistic assessment of safety as, despite some below-average figures, there was an upward trend in indicators. There had also been four self-inflicted deaths since the last inspection and in our survey one in four prisoners still said they felt unsafe.

2.4 Over half the respondents to our staff survey reported low morale and many staff were weary from delivering two years of constantly evolving COVID regimes. Despite this, we observed a mostly committed team of staff with a renewed energy and optimism inspired by the new governor, and the prospect of regaining some stability as the restrictions eased.

2.5 The majority of respondents in the staff survey said senior managers had taken time to listen to them. Lines of communication were well established through face-to-face briefings, a regular bulletin and some staff consultation events.

2.6 Staff attrition, non-effective staff and frequent cross-deployment had affected leaders' ability to deliver good outcomes in areas such as security and offender management. Not all the staff we observed were usefully occupied and potentially could have been used to deliver important tasks, such as key work.

2.7 Partnership working was fractured in some important areas. The imminent termination of the current health contract, as well as staff shortages on both sides of the partnership, had a detrimental impact on the service delivered. Similarly, vacancies in key roles in the education,

skills and work contract had not helped to drive much-needed progress in this area.

2.8 The decision to remove triple occupation of cells had been appropriate, but there were still too many prisoners living in overcrowded conditions. Plans had been approved for an additional house block, which could alleviate some of the problems. Despite some investment, living conditions across the prison were not good enough and leaders also needed to raise the standards set for staff and prisoners, particularly in cleanliness and behaviour.

2.9 Leaders and staff had not done enough to improve prisoner engagement in purposeful activities. Ofsted judged the overall effectiveness of education, skills and work to be inadequate.

2.10 Although the prison supported arrangements to consult prisoners and use peer work, both areas could be broadened and exploited further to improve communication and engagement with prisoners.

2.11 The prison's self-assessment highlighted that there was still much to do at Elmley, an honest account of the current position given that little progress had been made against our previous key recommendations. Leaders did not make good enough use of data to inform improvement plans and develop more robust quality assurance processes. Some priorities, including the need to address equality issues, were not underpinned by clearly defined strategies. We were left with some confidence that the senior team was keen to learn from scrutiny and committed to making the improvements needed.

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 Elmley received around 230 prisoners a month, with most coming from local courts. They disembarked from escort vehicles relatively quickly, but were still routinely handcuffed from the van into reception without risk assessment, which was disproportionate.

3.2 Reception staff put new arrivals at ease during the initial identification interview. Prisoners went through the body scanner to identify any illicit items but, as at the last inspection, most were also strip searched, which was often unnecessary. The reception holding rooms were clean and bright, but contained only limited useful information. Although the unit was busy, reception processes were completed swiftly, including dealing with prisoners' property; in our survey, 67% of prisoners said that they spent less than two hours in reception.

3.3 All new arrivals were taken to the first night centre, where they had interviews with an officer and a nurse. These lacked sufficient depth to identify risks and vulnerabilities, but this was offset by other opportunities to identify risk through the health screening.

3.4 Prisoners often arrived late in the day and most were not offered a shower or phone call on their first night. In our survey, only 13% said they could shower on their first night and 36% that they were offered a phone call.

3.5 The first night cells on house block 1 were bleak and unwelcoming. In our survey, only 27% of prisoners said that their cell was clean on their first night. Many were missing essential items such as tables, chairs and lockable cabinets, and some contained graffiti.

Double cell on house block 1

3.6 Induction was held on house block 1 over the following two days, but not all prisoners received a comprehensive programme. Arrivals identified as requiring alcohol detoxification and the majority of prisoners on opiate substation therapy were located on houseblock three. Despite the sizeable foreign national population, prisoners who did not speak English were not given an induction in a language they understood, and there was little use of professional telephone interpreting for non-English speaking arrivals.

3.7 On the day after arrival, prisoners could meet one of the prisoner Insiders who could tell them about the regime and life at Elmley. Insiders were approachable, knowledgeable and available to answer questions throughout the day, not just during induction. However, this lacked oversight and many new arrivals we spoke to did not know how to conduct basic tasks, such as how to submit an application for day-to-day services.

3.8 In the second part of the induction, new arrivals should have been briefed by staff about education and work opportunities, probation services and support from the chaplaincy, but both prisoners and managers told us that not all prisoners received this.

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

3.9 In the previous year, there had been less recorded violence between prisoners than at the last inspection and compared with similar prisons. However, there was evidence that this was beginning to rise. Assaults against staff and serious assaults against prisoners and staff were now at around the same level as at the last inspection, even though prisoners were locked up or subject to a more restricted regime. In the year to 31 January 2022, there had been 214 assaults against prisoners and 90 against staff. These figures included 37 serious assaults against prisoners and 12 against staff. In our survey, 24% of respondents said that they currently felt unsafe and 46% said that they had experienced some victimisation from other prisoners and 47% from staff.

3.10 Systems to understand and respond to the causes of violence were underdeveloped. Not all violent incidents were investigated and there was little evidence that lessons were learned from those that were. In the sample of investigations we reviewed, there was usually a lack of inquiry into why the incident happened and how it could have been prevented. The six prisoner violence representatives were used mainly to intervene in situations that were developing on wings; they did not have a direct link to the safer custody department or enough opportunity to contribute to an understanding of violence at Elmley. (See key concern and recommendation 1.42.)

3.11 A well-attended weekly safety intervention meeting provided useful advice on the support and management of individual prisoners with the most complex needs. However, challenge, support and intervention plans (CSIPs, see Glossary) were not used to full effect. There was an overreliance on the Incentives Policy and adjudication processes for perpetrators of violence or antisocial behaviour, and limited formal support for victims.

3.12 The safer custody team was well staffed. A comprehensive safety action plan underpinned the strategic vision for safer custody. It included work with young adults, who were overrepresented in violent incidents, and aimed for a wide range of work to promote safety throughout the prison. This work was not yet well embedded and progress against the action plan had been slow.

3.13 Leaders had not given enough thought to what motivates prisoners to behave. The incentives policy did little to motivate and encourage prisoners to reach the enhanced level of the scheme. The

accommodation on the enhanced unit was among the poorest in the prison, and there were too few opportunities for prisoners to progress while there. Prisoners on the general units told us they were not motivated to progress to the enhanced unit because there was little to differentiate it from their own units.

3.14 The basic level of the incentives scheme focused on punishment rather than motivating good behaviour. Improvement targets were generic and were not tailored to the individual. Despite regular reviews, most prisoners remained on the lowest level for the full 28 days, even when their behaviour had improved.

Adjudications

3.15 The adjudication records we reviewed indicated fair consideration of disciplinary charges, but there were weaknesses in the process. In the year to February 2022, only two-thirds of cases were brought to a substantive outcome with 49% proven and 17% dismissed; 13% were not proceeded with due to administrative problems. For example, in one case action could not proceed against a prisoner found in possession of a mobile phone because charges had been laid out of time. The adjournment rate was high. The prison was scheduling additional hearings to clear the backlog of remanded cases, which numbered 67 at the time of the inspection.

3.16 Very few cases were referred to the independent adjudicator (see Glossary). There had been no action on 39 serious cases referred to the police and there had been no prosecutions in the last 12 months, which meant that referrals had limited deterrent effect.

3.17 The deputy governor made a quality assurance review of a 10% sample of adjudication papers and fed back findings to managers. But oversight of the process through the quarterly segregation meeting was poor, as there was little focus on monitoring and addressing areas of inefficiency. (See key concern and recommendation 1.44.)

Use of force

3.18 There had been 361 uses of force in the previous 12 months, which was about 20% higher than at our last inspection. Use of batons and the PAVA incapacitant spray was infrequent: batons had been drawn on six occasions during this period and used three times, and PAVA had been drawn and used twice. The documentation we reviewed did not always fully detail the circumstances involving the baton or PAVA use or demonstrate the use of de-escalation techniques. There were no detailed investigations following their use to provide full assurance that they were proportionate and that lessons were learned. (See key concern and recommendation 1.43.)

3.19 Some prisoners told us that staff had assaulted them or others and deliberately did not turn on their body-worn cameras. Leaders did not currently do enough to address these concerns. Not all planned incidents were recorded and despite the availability of body-worn

cameras in each use of batons and PAVA in the previous year they were not always activated or were activated too late to assess fully if force was necessary. (See key concern and recommendation 1.43.) In the footage of use of force that we were able to review, staff were usually calm and competent and there were some good examples of de-escalation.

3.20 Managers reviewed all use of force incidents weekly, resulting in a range of useful learning points for staff. However, scrutiny had not led to resolution of the longstanding issue of staff not correctly activating body-worn cameras. The monthly use of force committee meeting demonstrated little evidence of effectiveness; outstanding actions often rolled over from month to month without progress.

3.21 The use of special accommodation had decreased, with four uses in the previous 12 months. All uses were justified in the documentation we reviewed.

Recommendation

3.22 **A senior prison manager should investigate fully all use of batons and PAVA to make sure that use is proportionate and that lessons are learned.**

Segregation

3.23 In the previous six months, 560 prisoners had been segregated. The average length of segregation was short at 5.1 days, which seemed proportionate. There were sufficient exceptional circumstances to segregate two at-risk prisoners on assessment, care in custody and teamwork (ACCT) case management during our inspection.

3.24 Relationships between staff and prisoners on the segregation unit were good. The staff had detailed knowledge of the prisoners. We observed respectful and professional relationships, and almost all prisoners we spoke to told us they felt well supported by the staff. Where needed, prisoners had good access to mental health staff, including the psychiatrist.

3.25 Cells on the unit were hot and uncomfortable. They were not sufficiently clean, although in reasonable decoration and with little graffiti. The exercise yards were bare, although one had some exercise equipment.

Segregation unit yard

3.26 In our survey only 30% of prisoners who said they had been segregated reported receiving a shower every day, against the comparator of 63%. Prisoners had not been receiving a daily shower, but this deficiency had been rectified at the beginning of February 2022. There was a large selection of books, which were changed weekly, and a good choice of games and puzzles and art materials, as well as three guitars to incentivise good behaviour.

3.27 Segregation reviews were multidisciplinary and involved the prisoner. During the inspection, the mother of a prisoner was invited to a review to help staff understand his needs better, which was notable positive practice.

3.28 There was some reasonable reintegration planning to make sure prisoners were not segregated for too long. In the previous six months, only five prisoners were transferred from the unit to another prison, with the rest returning to normal location in Elmley. However, radios were removed from some prisoners refusing to return to normal location, which was not appropriate.

3.29 There were weaknesses in the governance of segregation. Minutes of quarterly meetings were brief and did not evidence enough attendance by senior managers, or discussion based on the key strategic priorities. Leaders had not harnessed the potential of data to provide a greater understanding of segregation. (See key concern and recommendation 1.44.)

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.

3.30 There had been 5,603 intelligence reports in the last 12 months; those we reviewed were of reasonable quality. There was no backlog of unprocessed reports, which was a considerable improvement on our last inspection. There were now weekly tasking meetings, in which the security team briefed other staff on action needed to address the prison's risks.

3.31 There were, however, weaknesses in assessment of and action on intelligence reports. Recent monthly assessments did not address violence in the prison, even though it was considered one of its three main security risks. Staff redeployment meant that 60% of intelligence reports about prisoners holding unauthorised items, such as drugs or mobile phones, were not acted on with a cell search.

3.32 In the previous 12 months, 653 out of 3,139 security incidents were recorded as 'miscellaneous', rather than ascribed to specific indicators of security breaches. This was far higher than we usually see and indicated errors in the recording of issues relating to safety, leaving the prison poorly placed to understand and act on the problems it faced.

3.33 Physical security was generally sound. Security had been improved since the last inspection with the acquisition of a body scanner in reception and the recent installation of an airport-style arch detector for staff and visitors.

3.34 Most security procedures were proportionate, except for the continuing routine strip searching of prisoners in reception, who were also given a body scan (see paragraph 3.2). There was suitable risk assessment of prisoners being escorted to hospital, although not all had input from health care staff. A prisoner who had had physical contact with his partner in breach of COVID-19 restrictions was placed on closed visits for three months, which was disproportionate.

3.35 The prison was working with the regional prison team to address staff corruption. A contractor had recently been arrested for the trafficking of unauthorised articles. Regional staff had provided support to six staff considered to be vulnerable to being corrupted.

3.36 There were weaknesses in the governance of security. The minutes of monthly security meetings were brief and did not evidence enough attendance by senior managers or discussion based on the key strategic priorities. Poor assessment of data undermined the prison's understanding of some of the challenges it faced. (See key concern and recommendation 1.44.)

3.37 The strategic approach to drug supply reduction had greatly improved. The itemiser (see Glossary), new body scanning equipment and detection dogs were proving effective.

3.38 In the previous six months, there had been 57 suspicion-based drug tests with a positive rate of 60%, indicating good intelligence on substance misuse. However, this might have resulted in an increase in diverted medication and it was a concern that there was insufficient supervision of the dispensing of medication (see paragraph 4.84 and recommendation 4.94). The national suspension of mandatory drug testing throughout the pandemic left the prison without reliable data on drug use.

Recommendations

3.39 **All intelligence reports requiring a cell search should be acted on promptly**.

3.40 **HMPPS should review security incident reporting in Elmley to make sure that all incidents are categorised accurately.**

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

3.41 There had been four self-inflicted deaths since our last visit. The Prisons and Probation Ombudsman (PPO) had issued final reports into two of these, and the prison had conducted internal investigations for the two most recent deaths, identifying appropriate early learning points. Although recommendations arising from both the PPO reports and the internal investigations had been implemented, they were not monitored over time or subject to regular review to make sure that learning had been embedded.

3.42 Levels of reported self-harm were lower than in most comparable prisons, but had increased by 28% since our last visit and were on an upward trend over the previous 12 months. Analysis of self-harm data was poor and, as a result, leaders could only speculate on the drivers of this increase. Reducing self-harm was only briefly mentioned in the wide-ranging safety strategy, and leaders in this area told us that they expected reported rates to fall due to efforts in other areas, such as violence reduction and increasing time out of cell.

3.43 The safer custody team was well resourced and had recently introduced some initiatives and safeguards to identify and support prisoners at risk. For example, it reviewed daily wing observations

books to pick up individual incidents that could indicate that a prisoner needed additional support, such as requesting to speak to the Samaritans. Work was also under way to identify prisoners who appeared to be socially isolated, for example those who had not received any social visits or made any telephone calls for long periods, with the intention that a member of the safer custody team would then visit them.

3.44 Prisoners supported through the ACCT process were generally positive about the care they received and appreciated the additional interactions with staff, although the quality of support varied. Care plans were poorly completed and reviews did not attempt to address the underlying reasons for a prisoner self-harming. The safer custody team had a credible action plan to improve the quality of ACCT support.

3.45 The prison's Listener scheme (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) had restarted in the previous week. The service had been officially suspended and only used on an informal, discretionary basis since the introduction of COVID restrictions in March 2020. There were 17 trained Listeners, who were supported well by the Samaritans lead, and more Listeners were due to begin training. Most house blocks had dedicated Listener suites and the Listeners we spoke to said that staff had facilitated sessions both before and since the scheme had relaunched.

Protection of adults at risk (see Glossary)

3.46 The prison had a robust adult safeguarding policy that identified pathways of reporting and support, and staff at all levels were aware of their responsibilities. The deputy governor and head of safety were the named safeguarding leads, and links with the local authority were good.

3.47 Monthly safeguarding meetings were multidisciplinary, well attended and discussed prisoners at risk. Prisoners identified as needing additional support were referred to the local authority 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 We observed some friendly and relaxed interactions between prisoners and staff, who were visible and approachable. In our survey, 77% of prisoners said staff treated them with respect and 80% that they had a member of staff they could turn to, which was more positive than the comparator of 67% in similar prisons. Despite this, only 27% of prisoners said that a member of staff had checked in on them in the past week.

4.2 Although many staff were out patrolling landings, there were some prisoners in need of additional support who had not been identified. More meaningful staff interactions with prisoners would have been able to address this.

4.3 Around half the prisoners in our survey said they had experienced bullying or victimisation from staff. A quarter of staff who responded to our staff survey also said they had witnessed inappropriate behaviour towards prisoners. Most prisoners spoke positively about staff in general, but also highlighted a small number who contributed to tensions on the wing.

4.4 There was too little key work (see Glossary) at the time of the inspection. The quality and the frequency of sessions were inconsistent. The records we sampled were more like detailed welfare checks and there was little evidence of key work supporting sentence progression.

4.5 Several prisoners had been appointed in peer support roles and were visible around the prison. The substance misuse peer workers who were overseen by the Forward Trust had a clear role and were effective (see paragraph 4.81). However, other peer mentors were not supported in the same way; there were no job descriptions, training or oversight to maximise the potential of peer work.

Daily life

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

Living conditions

4.6 Around 30% of prisoners lived in overcrowded conditions, in cells that often could not fit sufficient furniture for two people. Many prisoners had resorted to using bedsheets to screen the exposed cell toilet. Most of the overcrowded accommodation was concentrated on house block 5, the category C unit, which did little to encourage progression there.

4.7 Leaders had not made sure that standards on residential units were set at a sufficiently high level and quality assurance was not yet effective in maintaining decent standards. Communal areas were not always clean. Cells were often untidy and not adequately equipped - for example, many had missing or damaged furniture and dilapidated flooring. The prison had begun to address this.

Cell

4.8 Although some showers had been refurbished to a good standard, too many were grubby and lacked sufficient privacy.

Showers

4.9 Most units had some cooking facilities (see paragraph 4.14) and specific areas to display various application forms and information. There was much more scope to improve these communal areas as most were bare and uninviting.

Cooking facilities

4.10 Prisoners had good access to cleaning materials, but equipment was not always appropriately labelled and used accordingly.

4.11 Over 70% of prisoners in our survey said they had weekly access to clean clothing and bedding. House blocks had sufficient laundry facilities for prisoners to wash their own clothes. Reception allowed prisoners to have parcels posted in every six months or every two months for those on enhanced status.

4.12 In our survey only 20% of prisoners said their cell bells had been answered promptly. The prison's recording system showed that around a quarter of cell bells took longer than five minutes to answer, and quality assurance was not yet effective in improving timeliness. Given the risks of self-harm and self-inflicted deaths, this should have been a priority for leaders.

Residential services

4.13 In our survey, only a third of prisoners said the food was good. During our visit, many complained that there were not enough food options to suit the population - the prison had not changed the menu since the pandemic had started. Prisoners had been consulted about the food, which was a regular item on the Elmley community group agenda (see paragraph 4.16), and this had led to some small changes. There had been some efforts to improve meals, such as breakfast packs, but the prison needed to do more.

4.14 It was positive that microwaves, fridges and toasters had been reintroduced on all residential units. Not all units provided separate facilities to suit different cultural or religious needs.

4.15 In our survey, 69% of prisoners said the shop catered for what they needed, compared with 55% in similar prisons. The shop provision was also a regular agenda item for the Elmley community group meetings. However, there were many valid complaints relating to the shop, with too many prisoners experiencing missing items, incorrect orders and unacceptable waits for refunds (see paragraph 4.20).

Prisoner consultation, applications and redress

4.16 The Elmley community group was the main forum for prisoner consultation. This group met consistently every month, and meetings were very well attended by a wide variety of leaders across the prison. However, prisoner attendance was not representative of the population, the process to select members lacked transparency and not all house blocks were always represented, all of which limited the usefulness of the forum.

4.17 The prison had also recently introduced monthly consultative wing meetings between house block managers and prisoners on their house block. This was a promising move forward in prisoner consultation, but there were similar issues with representation, regularity of meetings and inconsistencies in quality between house blocks.

4.18 There was a general lack of awareness about these avenues for consultation, which limited prisoners' input. The outcomes of consultation meetings were not shared and many prisoners were unaware that improvements, such as the introduction of covered bins, were the result of consultation.

4.19 There were weaknesses in the application system, which was paper-based, with carbon copies attached to the application form. Prisoners had limited access to forms. In many cases, staff were issuing photocopies without the important carbon copies that provided evidence an application had been submitted. Many prisoners said they were frustrated by the process and that they waited too long or did not get responses to multiple applications. The prison did not use monitoring to track applications but had developed an assurance system shortly before our inspection; it was yet to identify why the applications process was not working.

4.20 Prisoners at Elmley made a higher number of complaints than at other local prisons. Despite improvements to the system, responses we saw did not always address the complaint fully and they were not answered promptly; some prisoners had waited months for a response. The quality assurance process was not yet effective in improving responses. Leaders were beginning to analyse complaints to understand the trends and issues.

4.21 There were sufficient facilities for legal visits with 12 rooms available Monday to Friday. The video conferencing centre, with 13 rooms, also enabled prisoners to see their solicitors. Video conferencing was also used to facilitate court hearings, virtual visits for post-hearing meetings with solicitors, parole hearings, probation and psychiatric visits. The dedicated bail officer was in high demand and had supported 37 prisoners in securing bail in the previous year. The legal texts available in the library were limited and kept in a separate office, which made them more difficult to find (see paragraph 5.6).

Equality, diversity and faith

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

Strategic management

4.22 The prison lacked a clearly defined strategy to promote equality of opportunity and eliminate discrimination. There had been no analysis of the needs of prisoners with protected characteristics, which meant leaders could not set a clear direction for equality work to make sure

that the needs of their population were met. The structure to improve work in this area was in place, but it was underdeveloped. An up-to-date equality policy outlined key responsibilities and processes, and a monthly diversity and inclusion meeting was attended by prisoner representatives. The meeting examined local data and leaders had compiled an action plan to address some identified shortfalls. However, without understanding the needs of each protected group, leaders could not determine the most appropriate actions, provide the right support or improve outcomes. (See key concern and recommendation 1.45.)

4.23 A programme of consultation with prisoners with protected characteristics had recently restarted and senior managers had been identified as leads for these groups. Not all equality leads attended the forums for their groups and some were not active or effective in their roles. Records from the forums were brief and actions were not always added to the equality action plan, which made monitoring progress difficult. It was too early to assess the impact of current consultation initiatives. (See key concern and recommendation 1.45.)

4.24 Many prisoners with protected characteristics expressed frustration at the level of unmet need and inconsistencies in the priority and focus given to different groups. For example, foreign nationals made up 18% of the population yet no senior lead had been appointed for this group and there were no plans for consultation. Staff were aware of the need to prioritise this group but action to develop a foreign national prisoner strategy had been outstanding for several months. (See key concern and recommendation 1.45.)

4.25 We heard several complaints from prisoners about racist attitudes from some staff.

4.26 Diversity and inclusion peer representatives had been appointed across all house blocks. but oversight of their role. They had not been given a role description, a job compact or training. They were not provided with adequate formal support from leaders to help them provide the best service to their peers.

4.27 Our scrutiny of discrimination incident report forms (DIRFs) indicated that most responses were polite and thorough. It was not always clear if the prisoner had been involved in the investigation or informed whether the DIRF had been upheld. There were some weaknesses in the tracking system that did not provide assurance of timeliness. DIRFs were not always easy to locate on the house blocks.

Protected characteristics

4.28 During the inspection, we heard repeated anecdotal accounts about poor treatment of prisoners with protected characteristics and found some evidence to support negative perceptions.

4.29 In our survey, 18% of respondents said they were from a racial minority, against the comparator of 30%. The prison's own analysis

identified disproportionate outcomes for this group, for example in the allocation of jobs. Leaders had taken some steps to address this but prisoners we met during the inspection still expressed great frustration about this inequality. In our survey, 13% of prisoners said they were from the Gypsy, Traveller or Roma community, far more than the comparator of 3%. Prisoners from this group told us they felt overlooked by staff and leaders. In our survey, 69% said they had been prevented from making a complaint compared with 24% who were not Gypsy, Traveller or Roma. Consultation with this group had only recently restarted, but leaders had done little to understand and address their needs.

4.30 Foreign national prisoners made up 17% of the population. These prisoners had been located mainly on one house block to meet their specific needs, which was positive. While some staff on the house block were well intentioned, there was limited appropriate support for these prisoners. The paucity of translated materials across the prison was a barrier for foreign nationals, and the use of professional interpreting was minimal. Many prisoners we spoke to, not just foreign nationals, described this group as being overlooked or ignored. In our survey, 55% of foreign nationals said they felt unsafe, compared with 20% of British prisoners, and only 25%, against 61%, said it was easy to make a complaint. Again, leaders were doing too little to understand and address the negative experiences of this vulnerable group.

4.31 During our inspection, 17 foreign nationals were being held under immigration powers following completion of their sentence, the longest for over nine months. Although Home Office immigration staff attended the prison once a week, detainees told us they were not given meaningful information on the progress of their case and that this caused distress. These detainees had limited access to independent legal advice and were not able to telephone Legal Aid Agency-funded immigration surgeries. Home Office immigration staff were unable to provide information on the duration of immigration detention for those on their caseload or which detainees had been assessed as 'adults at risk' – this left a critical gap in the development of care plans and the monitoring of potentially vulnerable detainees.

4.32 Six per cent of the population were aged under 21 and the prison had identified disproportionate outcomes for this group. For example, young people were more likely to be on a basic regime and be unemployed. There was evidence of some promising work to address this, such as a dedicated young adult action plan and a monthly dedicated safety intervention meeting.

4.33 In our survey, 19% of respondents were aged over 50. There was little specific provision for this group other than a gym session that prioritised, but was not dedicated to, older prisoners. However, the older respondents to our survey and most of those we spoke to during the inspection said that they felt safe and that their needs were mostly met.

4.34 Half of our survey respondents considered themselves to have a disability and they reported more negatively than prisoners without a disability about their experiences in several areas. For example, 32% of disabled prisoners said they felt unsafe at the prison, compared with 15% of those without a disability. Although forums for this group were planned, there had been no consultation for several months and the prison was poorly placed to understand their specific needs. There were 46 prisoners with a personal emergency evacuation plan (PEEP), but the plans were stored electronically and not readily available, which left too many staff unaware of how to help disabled prisoners in an emergency. Some house blocks had identified prisoner 'Buddies' as carers for those with PEEPs, but this was informal and, like other peer support, their roles did have any support or training.

4.35 Seven percent of respondents to our survey told us they were homosexual, bisexual or of other sexual orientation. We found little evidence of engagement with this group other than a recent forum. There was one transgender prisoner, who had refused a case board review. The senior lead for transgender prisoners was active and the papers we reviewed showed that the prisoner had been included in decisions and their individual need had been considered.

Faith and religion

4.36 The chaplaincy provided much-needed pastoral care and support, which prisoners greatly valued. The team had adapted services during the pandemic in response to need. This was particularly evident in the event of bereavement, with chaplains providing family liaison duties, facilitating funeral attendance via video streaming, and providing counselling and support. The team stated an ambition to continue fulfilling its statutory duties with the staff available, but the paper-based records made it difficult to monitor data relating to this.

4.37 In our survey, 55% of all prisoners said they could speak to a chaplain of their faith in private if they wanted to; this response was only 24% for foreign nationals compared with 59% of British prisoners. The lack of translated materials was a major gap (see paragraph 4.30).

4.38 The large chapel was reasonably well equipped with information and materials to cater for a range of faiths. Opportunities for corporate worship remained far too limited, with Christian and Muslim prisoners only able to attend Sunday service or Friday prayers once every six or seven weeks.

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.

4.39 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 found there were no breaches of the relevant regulations.

Strategy, clinical governance and partnerships

4.40 Integrated Care 24 (IC24) held the current primary care contract and Forward Trust provided a drug and alcohol treatment and intervention service. Mental health services were delivered by Oxleas NHS Foundation Trust. Oxleas had been successful in its bid to provide all Elmley's health services from April 2022, apart from the dental service which was continuing with the current provider, Chopra and Associates.

4.41 The health needs analysis, refreshed in 2016, required updating to make sure it remained relevant to the needs of the population. Partnership board meetings had continued during the pandemic. NHS England and Improvement and the prison had concerns about the current service provision and had implemented weekly monitoring. Despite challenges, partners had pulled together to manage COVID-19 outbreaks through effective contingency planning.

4.42 Many prisoners expressed frustration about access to health care with appointments rescheduled, often with very limited notice. Maintaining adequate staff levels in all health teams had been very challenging and had greatly affected the delivery of services. This was mainly in the primary care service, where staffing levels had been critically low, with prioritisation of essential services. Staff levels had improved slightly and the team was now running clinics on the wings where possible. GPs were covering gaps in the provision, including the treatment of long-term conditions.

4.43 IC24 managers frequently had to carry out clinical duties to cover staffing deficits and could not always focus on the strategic aspects of their roles, including some elements of governance. Mandatory training levels were reasonable, although some IC24 staff had not undertaken basic life support training. Most services had provided appropriate supervision. However, while primary care staff felt supported, they had not received regular managerial supervision (see key concern and recommendation 1.46).

4.44 Prison-related issues continued to hinder the delivery of health services. For example, the limited times available for hospital escorts had affected prisoner access to appointments in the community, where long delays were commonplace. Appointments in the health care department were also affected because patients were not always escorted to them, lengthening waits and wasting clinical time (see key concern and recommendation 1.46).

4.45 Clinical incidents were discussed at governance meetings; the current providers used different electronic reporting systems, but the new provider will use one system. There were gaps in the written follow-up for some IC24 incidents. Those we sampled had been followed up, but

the investigation and outcomes had not been recorded. It was not clear how learning from these incidents was shared with staff (see key concern and recommendation 1.46). There was good oversight and reasonable progress on the health recommendations from the Prisons and Probation Ombudsman (PPO) death in custody reports.

4.46 Patients had access to a confidential complaints system, although it was not clearly advertised. Receipt of complaints was acknowledged within three days, with each provider undertaking more formal investigation and generally responded within 25 days. Responses were concise, polite and included an apology, but they needed to be more 'customer-focused', reflecting any learning identified as a result of patient concerns and communicating this back to them.

4.47 The health centre environment complied with infection prevention and control standards, and regular hand hygiene audits were completed.

4.48 Emergency equipment was placed strategically around the prison. The emergency bags were not sealed and there were a few gaps in the recording of daily checks. We also found an out-of-date medicine and the pads of the automated external defibrillator open rather than sealed, which were replaced once we identified this.

Promoting health and well-being

4.49 The main health promotion focus had been on managing the current COVID-19 outbreak. The overall uptake of COVID-19 vaccinations was lower than anticipated, despite encouragement and ongoing education and guidance. IC24 had liaised with the local health protection team in managing some positive cases of scabies and had good links with the tuberculosis specialist team at the local hospital.

4.50 The team followed a calendar of national health promotion programmes. Health information was available, but the fact that there were versions translated into foreign languages was not well advertised. Health staff used telephone interpreting services when needed.

4.51 External sexual health services had resumed their clinics. Barrier protection was available but not well advertised.

4.52 During secondary health screening, all new arrivals had been offered testing for hepatitis C and other blood-borne viruses. Treatment for hepatitis C, and hepatitis B vaccinations had continued. A range of prevention screening programmes was offered, including retinal and bowel cancer screening.

4.53 Smoking cessation was offered on an individual basis via the GP.

Primary care and inpatient services

4.54 All new arrivals received an initial health screening from the primary care team and were seen by the substance misuse service and the GP when needed. Appropriate referrals were made. COVID-19 testing was

offered on arrival and day five following arrival. A secondary health screen was completed within the seven-day guidelines. Patients were seen before release and given four weeks' medication if needed.

4.55 Health staff were caring and dedicated. Due to staff shortages, primary care had moved to become a flexible reactive service, which helped make sure patients' health needs were met. More recently, this had included moving to a wing-based service where nurses were allocated based on their individual expertise to meet the daily needs of patients on specific units.

4.56 The application system for health care appointments was not currently suitable. Applications were clinically triaged, with prisoners allocated an appointment or placed on a waiting list. Due to the current staff shortages, prisoners were not informed of this until the day of their appointment, leading to frustration and an increase in non-attendance (see key concern and recommendation 1.46).

4.57 Allied health professionals had continued their clinics, with reasonable waiting times. Due to nursing staff shortages, the GP service had taken on additional duties to help meet the needs of patients. This had lengthened the wait for routine GP appointments, which was now just over four weeks and was too long, although urgent slots were available daily. The high number of non-attendances at GP appointments also affected waiting times (see key concern and recommendation 1.46).

4.58 The management of patients with long-term conditions, such as diabetes and epilepsy, was GP-led. Comprehensive case notes showed that patients received their annual reviews at the right time and were seen promptly by appropriate services, such as podiatrists and opticians. The asthma clinic was nurse-led and, when sustained staff numbers improved, the new provider would seek a more nurse-led approach to all long-term conditions.

4.59 A nurse-led multidisciplinary chronic pain clinic, run by Kent Community Health NHS Foundation Trust, provided a valuable service in the prison. It helped patients to manage and overcome the challenge of suffering with long-term pain and receive the most appropriate pain relief.

4.60 The administrative oversight of external hospital appointments was good, but too many appointments were cancelled due to prison operational issues, including lack of prison officer escorts. This was further compounded by long community waiting times caused by the pandemic.

4.61 During the inspection, the 21-bed inpatient department accommodated 17 patients, all with mental health needs, who received reasonably good care. Maintaining adequate health staff had been a problem but this had improved. Medical cover, including the GP and consultant psychiatrist, was good. A regular group of prison officers worked on the unit to aid consistency. The area, while clean, needed refreshing to create a more therapeutic environment, as well as an increase in

therapeutic activity. Oxleas was due to complete ligature risk assessments in the department when it took over the contract in the following weeks.

Social care

4.62 The prison had well-established links with Kent County Council for the provision of social care. The memorandum of understanding needed reviewing to make sure all the information was up to date. A dedicated and ring-fenced social care team, consisting of an occupational therapist and social worker, completed assessments promptly for prisoners identified as having a social care need.

4.63 There were currently two prisoners receiving social care support. Their agreed comprehensive and personalised care plans were adhered to and all their needs were met consistently by sufficiently trained and compassionate external domiciliary care agency staff.

4.64 When referrals were made, a range of specialist equipment was provided to help promote independence and enable safe care and treatment for those with an identified need.

4.65 Information leaflets in an easy-read format had been circulated to increase prisoner self-referral. Leaflets and posters had also been displayed around the prison to raise prison officer awareness of how to identify a social care need and make a referral.

4.66 There was competent planning of an effective well-coordinated care pathway, including continuity of care on release into nursing/residential homes, and ensuring packages of domiciliary care were in place.

Mental health care

4.67 Against a background of major workforce shortages, mental health services responded positively to prisoners in need of urgent support. Those needing to access routine psychological care waited longer, but caring staff encouraged and helped them to use other support, such as guided self-help and the chaplaincy, during this time.

4.68 Both the mental health in-reach team and the Bradley Therapy Service provided by Oxleas delivered a stepped model of care for patients with mild to moderate and more complex needs. The teams comprised skilled and experienced mental health practitioners from nursing, psychology, counselling and support backgrounds, and regular psychiatrist input. A nurse had been appointed to support prisoners living with a learning disability, but gaps remained in the provision for patients with neurodevelopmental/neurodiversity needs. Staff vacancies and sickness had affected the delivery of some aspects of the service, including attendance at reviews of prisoners in crisis on assessment, care in custody and teamwork (ACCT) case management.

4.69 The mental health in-reach team reviewed referrals received from a variety of sources, including self-referral, daily. A routine assessment was undertaken within five days. The daily duty worker role worked well

to cover any urgent referrals, who were seen within 48 hours. Mental health services worked Monday to Friday, 8am to 4pm, with limited support at the weekend.

4.70 The team's 'Early days' pilot, providing immediate mental health support to prisoners within their first seven days in custody, had been well received by the prison.

4.71 Care planning, risk assessment and general record keeping was of an acceptable standard. We found some examples of high-quality and detailed care plans.

4.72 Plans to recommence therapeutic groups for those seeking support for mild to moderate mental health problems were planned but had been affected by regime changes due to the current COVID-19 outbreak.

4.73 Psychologists offered longer, higher-intensity therapeutic interventions for individuals with more complex presentations. The waiting list remained lengthy, although individuals were supported while they were waiting via workbooks and guided self-help.

4.74 Between October and December 2021, there had been eight transfers to hospital under the Mental Health Act. Five went within the national guidelines of 28 days, but the others exceeded this by between three and five weeks.

4.75 There was generally effective discharge planning and close liaison with other partners and community providers to make sure there was continuity of care following release.

Recommendation

4.76 **The transfer of patients to hospital under the Mental Health Act should take place within agreed Department of Health timescales.** (Repeated recommendation 2.78.)

Substance misuse treatment

4.77 There was an up-to-date drug strategy, although the last needs assessment was in 2017 and required updating. There had been a refreshed focus on drug strategy meetings with good oversight of local issues. Forward Trust staff attended regularly and 1C24 provided written updates when unable to attend. An action plan, based on some historic work, had recently been updated. There were good links with the security team who communicated relevant intelligence about any illicit drug finds.

4.78 Support for prisoners with substance misuse needs was reasonably good. New arrivals with drug and alcohol problems received safe support, and clinical treatment arrangements were flexible, responsive to need, followed national guidelines and were reviewed regularly.

4.79 The majority of opiate-dependent new arrivals and those experiencing alcohol withdrawal were placed on house block 3, which benefited from

24-hour nurse cover for observation and monitoring. During the inspection there were 104 prisoners on opiate substitution treatment, with 13 on reduction regimes and the rest on maintenance doses. We observed competent medicine administration and well-supervised queues, although there was not always effective officer supervision on other house blocks.

4.80 Around 38% of the population, 410 prisoners, were being supported by drug and alcohol workers. The service had been affected by staff shortages resulting in a backlog of assessments. The wait for a routine psychosocial assessment was around two weeks, but the service prioritised interventions based on risk and was focusing on key areas of delivery, including attendance at ACCT reviews and supporting individuals suspected of using illicit substances.

4.81 Due to COVID-19 regime restrictions, group work had been suspended and individual work was prioritised. A focus on harm minimisation and a range of workbooks were on offer. The service had initiated some creative activities to provide distraction, such as sewing kits, which had proved popular. A mutual aid group run by Alcoholics Anonymous was due to restart. There were currently five peer supporters who were very well supported and trained and supervised by a staff coordinator. The peer supporters ran a drop-in session on one of the house blocks to support prisoners who had a problem or query about substance misuse issues. There were plans to extend this.

4.82 The team prepared prisoners for release in good time; it coordinated care with community services to ensure continuity of opiate substitution treatment, gave harm minimisation advice and provided naloxone (to reverse the effects of opiate overdose) to take home, as required.

4.83 Paper case notes were kept, which were also recorded on Nebula, an electronic record that was not accessible to other health providers. This was onerous and not in line with good practice as a single contemporaneous set of health records should be used. The team also used SystmOne (the clinical IT system) for prescribing and clinical interventions, and for a summary of psychosocial interventions.

Medicines optimisation and pharmacy services

4.84 The lack of staff had affected the services the pharmacy could provide. Patients had limited access to the pharmacy team and medicine reviews, and there were no pharmacist-led clinics.

4.85 Medicines were supplied promptly from HMP Rochester. Around 60% of patients received in-possession medicines, and supervised medicines were obtained in pre-labelled bags. Medicines, including those requiring cold storage, were generally stored appropriately, although we found a few gaps in the daily recording of fridge temperatures.

4.86 Medicine administration was mainly nurse-led and administered from the wings at appropriate times. Officer supervision of medicine queues

was inconsistent in both numbers and practice, which increased the risk of diversion.

4.87 A range of medicines was available in the emergency stock cupboard and patients could receive over-the-counter remedies, but record keeping and reconciliation procedures were not robust. Stock medicines were not audited and reconciled at regular intervals so that any potential anomalies could be identified and investigated promptly.

4.88 Transfer of medicines to house blocks was not always secure. We observed some staff using open baskets to transfer medicines, which could compromise their safety. There were risk assessments of the patient and the medicine, and these were reviewed when the patient's circumstances changed.

4.89 Prescribing of medicines liable to abuse, such as co-codamol and dihydrocodeine, remained relatively high. These were given in possession, which increased the risk of diversion and needed to be reviewed. Prescribing of zopiclone (a hypnotic used to treat insomnia) had been reduced significantly since the last inspection.

4.90 Not all the clinical incident reports we saw were complete, including medication incidents. Contributory factors and outcomes to prevent similar events were often omitted. There was little evidence of individual reflection and learning from these events (see key concern and recommendation 1.46).

4.91 The prison undertook some random cell checks for prohibited items, but these were mainly intelligence-led rather than regular spot checks. Potent medicines could be supplied without the need to see a doctor through patient group directions, but these were currently not in use.

4.92 There were regular Kent Prisons' Medicines Management Committee meetings, which the prison attended.

Recommendations

4.93 **Stock medicines should be audited and reconciled at regular intervals to identify anomalies and investigate them promptly.**

4.94 **Prison officers should consistently monitor and manage medication administration queues to reduce the opportunities for bullying and diversion, and to maintain patient confidentiality at the hatch.** (Repeated recommendation 2.95.)

Dental services and oral health

4.95 The dentist provided a responsive and flexible service, offering a range of NHS dental treatments. Advice on effective oral hygiene was given routinely and disease prevention was promoted.

4.96 Due to the pandemic, additional clinics had been commissioned to reduce waiting times, which were now at just over four weeks. Follow-up appointments were completed promptly and slots were set aside to

see urgent referrals. Out-of-hours provision was available when required. Non-attendance rates in the dental service remained high and there was ongoing work to reduce these numbers and improve patient attendance.

4.97 The dental suite was clean and met infection prevention and control standards, patients benefited from a high-quality environment, and the equipment was well maintained and serviced regularly. An air purification unit was in place to ensure the circulation of clean air. There were no separate decontamination facilities, which would have complied with best practice.

Section 5 Purposeful activity

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

Time out of cell

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

5.1 The prison had introduced a less restricted regime in the week of our inspection that allowed for increased time out of cell. Around a third of prisoners were employed full time and they had up to seven hours a working day out of cell. Part-timers were not in work every day and so only benefited from up to seven hours out of cell when they attended activity, which was often only a couple of sessions a week. Up to 400 prisoners who were unemployed were unlocked for around four hours a day, alternating between the morning and afternoon. On weekends, most prisoners were unlocked for only three hours a day. Prisoners on house block 5's enhanced spur had an additional evening association, giving them up to nine hours out of cell.

5.2 During our roll checks we found one-third of prisoners locked behind their doors which, while still high was lower than in similar prisons. Our roll checks also found that only one-third of prisoners were in purposeful activity. Capacity and opportunities to engage in purposeful activity were too limited.

5.3 Prisoners on house blocks 1 to 4 received 30 minutes a day in the open air, those on house block 5 had around 45 minutes and those on house block 6 could have around 90 minutes a day outside.

5.4 Aside from the pool tables and table tennis, there was little other social or recreational activity for prisoners during times of unlock. Most house blocks had no communal seating areas and we saw prisoners standing around the railings during association with little else to do. Exercise yards were adequate and had some gym equipment. The enhanced unit on house block 5 had some green spaces and was less restricted.

Table tennis table

5.5 After a long period of closure, the library was now open and prisoners were offered two sessions a week. Although numbers were limited to six per session, which was too few, the facilities were complemented by an outreach service facilitated by library representatives on each house block, which provided books for those not able to visit the library. A selection of books was also available on the house blocks. This was greatly valued during the closure of the library but was no longer being regularly refreshed in all areas. Around 50% of the population were registered as users, lower than at our last inspection. Data on library use were collated and compared against population statistics, but too little was done to understand why prisoners were not attending or to widen participation.

Library

5.6 The welcoming library was managed by Kent County Council and stock could be reserved from a wide pool of other libraries, including other prisons. The range included a variety of audio books, large-print and easy-read books, as well as a reasonable selection in foreign languages. Some limited legal texts and booklets were available, but these were kept in the office, and it was not evident that prisoners knew how to access them (see paragraph 4.21).

5.7 The prison's excellent physical education facilities included a large and well-equipped gym, sports hall, weights annex and classrooms. The timetable offered prisoners on each house block (apart from the reverse cohort unit on house block 1) a minimum of four sessions a week, but monitoring data was far too limited. There had been little attempt to understand which prisoners did not attend, leaving the prison poorly equipped to target services or encourage wider participation. The department's provision of several accredited courses had paused during the pandemic, but there was now a timetable to recommence this provision, and the prison had recently restarted delivery of one-day courses with a focus on employability for prisoners, which was positive.

Recommendation

5.8 **Gym use should be monitored and underrepresented groups encouraged to participate in physical education and fitness provision.**

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.

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

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Requires improvement

Personal development: Inadequate

Leadership and management: Inadequate

5.10 The quality of education was inadequate. Leaders did not make sure that teachers planned their curriculums to meet the needs of the prisoners they taught. Teachers focused on the criteria that prisoners needed to pass courses, rather than on the knowledge and skills they most needed to develop. (See key concern and recommendation 1.47.)

5.11 Leaders and managers rightly recognised many of the weakness that inspectors found. Although leaders had begun to tackle these issues, at the time of the inspection their actions had not had enough impact. Only half of the recommendations from the previous inspection had been achieved.

5.12 Teachers did not access development activities that supported them to improve their teaching practice. For example, there was insufficient focus on supporting teachers to plan for prisoners' differing ability levels and needs. Furthermore, when leaders carried out quality assurance activities, they did not place enough focus on the impact of the curriculum on prisoners.

5.13 Leaders had ensured that teaching staff had appropriate teaching and training qualifications. Those who did not hold a teaching qualification when they started their roles received support to gain one. Vocational trainers had suitable industry-related experience and expertise.

5.14 Pay rates for prisoners did not offer them enough incentive to study mathematics or English. Leaders had advanced plans to address this issue by making appropriate changes to the pay policy.

5.15 Leaders did not use data effectively to monitor the quality of education. For example, they did not thoroughly track trends in prisoners' enrolment, retention and achievement, nor did they use this information to tackle weaknesses in the education provision. (See key concern and recommendation 1.48.)

5.16 Prisoner induction to education, skills and work was ineffective. Too many prisoners did not attend their induction appointments because they lacked motivation. Those who did attend received too little information about what they could do while at the prison and, as a result, they could not make informed choices about their work or study options. Staff discussed sensitive and confidential information with prisoners in front of their peers, which meant that some were reluctant to discuss their study or support needs. Teachers and peer mentors did not accurately mark mathematics and English assessments designed to check prisoners' starting points. (See key concern and recommendation 1.49.)

5.17 The provision of careers information, advice and guidance was poor. Too few prisoners benefited from ongoing advice and guidance about future career options. Prisoners did not have access to the 'virtual campus' (internet access to community education, training and employment opportunities) to conduct job searches. At induction, teachers and mentors set unrealistic or vague career-related targets. Prisoners did not have a clear understanding of what they were working towards.

5.18 Staff responsible for allocating prisoners to education, skills and work activities considered issues such as risk assessment closely. Recent and appropriate changes to their processes meant that remand prisoners could access a greater variety of activities. In too many cases, though, allocations staff did not routinely look at what prisoners planned to do in their future career when selecting work/education activities for them. As a result, most prisoner allocations did not match their career goals and aspirations.

5.19 In many subjects, such as mathematics and English, teachers took too few opportunities to revisit topics or check work that learners had completed independently. As a result, prisoners made slow progress in their studies and did not develop a secure knowledge of key topics. In these subjects, frequent changes in teachers had led to a lack of continuity and had inhibited prisoners' progress.

5.20 Too few prisoners achieved the qualifications that they had worked towards. On English and mathematics courses, in particular, few prisoners successfully completed their qualifications. (See key concern and recommendation 1.48.)

5.21 Teachers did not provide prisoners with clear and direct feedback to help them improve their written work. Consequently, prisoners repeated errors in subsequent work.

5.22 In a few cases, teachers used coaching techniques effectively when working with individual prisoners. They encouraged them to work out the correct answer where they had made an error, for example during wing-based outreach support for those who studied English for speakers of other languages (ESOL).

5.23 Most prisoners who studied via a wing outreach course did not receive adequate support. Teachers taught new topics in a disjointed manner, which confused prisoners. Too many outreach sessions did not take place because of poor communication between teachers and wing staff. Prisoners did not have access to basic resources to support their studies, such as dictionaries or calculators.

5.24 There were enough activity spaces for most prisoners, but the number who attended education, skills and work activities was not high enough. Too many prisoners demonstrated a lack of motivation and refused to attend the education, skills and work activities to which they had been allocated. Leaders had identified that younger prisoners were most likely to refuse to attend activities. They focused well on finding out the reasons behind this and had made progress with re-engaging a few prisoners who had missed learning.

5.25 In vocational training sessions, prisoners benefited from good-quality support from tutors, which helped them to develop new skills. For example, prisoners on the barista course learned how to maintain equipment appropriately and also developed useful teamworking skills. Those who studied tiling learned to cut and measure tiles accurately.

5.26 Peer mentors were active in most classes and workshops, as well as on wings, and motivated to fulfil their roles. However, in too many cases teachers and wing staff did not plan their mentoring tasks effectively. Most peer mentors had not undertaken accredited training or qualifications, which meant that support was too often vague or ad hoc.

5.27 Support for prisoners with learning difficulties and/or disabilities (LDD) was inadequate. Staff responsible for writing support plans did not identify appropriate support strategies for these prisoners. Prisoners who required a more in-depth assessment of their needs had to wait too long for an assessment before their needs were addressed. Too many teachers lacked the ability to help prisoners with LDD. As a result, prisoners with identified needs did not receive enough support in lessons. For example, those with attention deficit hyperactivity disorder

(ADHD) did not have sufficient access to resources that would help them to concentrate. (See key concern and recommendation 1.50.)

5.28 Leaders had used local market information to plan alterations to the vocational curriculum, but the pandemic had limited their ability to implement changes. Leaders did not provide opportunities for eligible prisoners to gain useful work experience via release on temporary licence.

5.29 Leaders had maximised the number of education, skills and work spaces available to prisoners under the COVID-related restrictions applying to the prison at the time of the inspection. However, there were too few places available in subjects such as mathematics and ESOL.

5.30 Prisoners from most wings could access a suitable range of courses, including programmes such as music, mindfulness and art, which helped a few prisoners to improve their mental health. They talked openly about their feelings, their trigger points for anxiety and also built up their levels of resilience.

5.31 A small number of prisoners who were at risk of self-harm had improved their mental health through attending education classes. They felt valued and listened to, and had increased their confidence and self-esteem.

5.32 Vulnerable prisoners had very few opportunities to develop vocational skills ahead of their release as they had no access to vocational training classes. They had limited access to work activities, and minimal opportunities to gain accredited qualifications, which undermined leaders' promotion of equality and inclusivity.

5.33 Leaders and teachers did not plan curriculums to help prisoners develop their knowledge of fundamental democratic values, equality of opportunity and inclusivity. In a few cases, teachers planned useful activities to help prisoners explore current news stories. Prisoners showed an awareness of the importance of listening to and respecting opinions that were different to their own and considered stories from a variety of viewpoints.

5.34 Prisoners behaved well during most classes. They arrived at sessions punctually and were ready to study. Teachers and instructors challenged poor behaviour promptly and prisoners responded appropriately.

5.35 Those prisoners who attended education, skills and work activities demonstrated a positive attitude. Wing workers mostly completed tasks diligently. Prisoners felt safe in classrooms and workshops, and they wore appropriate personal protective equipment for their roles. Prisoners who studied vocational subjects valued the skills they gained to prepare them for employment, such as knowledge of professional expectations in the workplace.

5.36 Although much support for prisoners' career development was weak, leaders had made beneficial links to external employers. The 'Accelerator' programme (see Glossary) had had a positive impact on prisoners' ability to engage with these employers, particularly when they were close to release. They could access up-to-date job vacancies, as well as meet employers at job fairs. Prisoners who attended these events behaved professionally and demonstrated a keenness to improve their job prospects. The proportion of prisoners who went directly into a job on release had increased, but remained low.

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 Leaders had been committed to making sure that prisoners could receive visits in person from family and friends, and had increased the number of visits offered at the earliest opportunity following the relaxation of COVID restrictions. Visits were now available seven days a week, with each session lasting two hours and able to accommodate up to 46 prisoners and their visitors. While the children's play area and café had not yet reopened, the visits experience was much better than it had been throughout the pandemic.

Visits hall

6.2 Sentenced prisoners on the standard level of the incentives scheme could have four visits a month and those on the enhanced level six, while remand prisoners could have three visits a week, which was

excellent. Take-up of visits in recent months had been at about 70% of available spaces. This could have been attributable to a lack of communication from the prison about improved entitlements, as many prisoners and visitors we spoke to were unsure how many visits they could book.

6.3 Only 24% of respondents to our survey said it was easy for family and friends to get to the prison, against the comparator of 35%. Although transport options remained limited, the prison had negotiated with a local bus company to extend one of its routes to the visitors' centre outside the prison gate.

6.4 The Spurgeons charity family services workers (FSWs) staffed the visitors' centre and supported the prison with family work, which included offering prisoners in-cell family relationship workbooks. FSWs were not contracted to carry out casework with prisoners, such as dealing with the family court, although they would speak to individual prisoners on request. The FSWs had also led on family initiatives, such as taking photos of prisoners beside a Christmas tree to send to families over the festive period and preparing Valentine's Day gift boxes that were delivered to prisoners with personal messages. Prisoners greatly appreciated these initiatives. Spurgeons also supported family days and had produced a schedule of such events for 2022.

6.5 All prisoners had in-cell telephones, enabling them to maintain good contact with families. In our survey, 96% said they could use a phone every day, a rise from 88% at the previous inspection.

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 Since the previous inspection, Elmley had undergone a role reconfiguration and now held sentenced category C prisoners as well as remand prisoners received from the courts. We found little distinction in the treatment and opportunities for prisoners of different categories. There were too few opportunities for category C prisoners to progress through their sentence, with almost no opportunity to benefit from an offending behaviour programme. There was still no agreed plan for how release on temporary licence (ROTL) would be reintroduced to enable prisoners to demonstrate they had reduced the risks they posed.

6.7 The newly appointed head of reducing reoffending was leading the recovery of work in this critical area. A needs analysis of the population had recently been completed and, while this was based solely on a prisoner survey, it had been used to develop a useful set of

recommendations to improve outcomes. This was complemented by a recently revised reducing reoffending strategy and action plan. The updated meeting structure clearly articulated how the work of the many partners supporting this work would be coordinated, with a clear focus on using data to inform plans. During the inspection, the resettlement team was being relocated to work within the offender management unit (OMU), which was a positive step.

6.8 During 2021, the OMU had experienced significant shortfalls of probation prison offender managers (POMs). As a temporary measure, prison POMs were used to fill these roles to manage high-risk prisoners. Although there were now five probation POMs, some of the prison POMs still had high-risk prisoners allocated to them, which was inappropriate. Managers reallocated these cases as soon as we highlighted this.

6.9 In addition to the probation staff there were 12 prison POMs, five of whom were operational prison officers. Most POMs held a caseload of between 30 and 40 prisoners, which was not excessive. However, the operational POMs continued to be regularly cross-deployed, and in January 2022 alone this resulted in a loss of almost 300 hours of POM work. The prison reallocated some of this work, although in at least one case, the absence of the POM had led to delay in a prisoner being able to apply for release on home detention curfew (HDC). We also spoke with a prisoner who felt he was disadvantaged as his categorisation review was completed by a POM who did not know him.

6.10 POMs told us that their work was predominantly task-led, completing paperwork to meet the next deadline instead of spending valuable time supporting and motivating prisoners. In our review of cases, most contact between POMs and prisoners was not good enough. For example, one prisoner spending their first time in custody had arrived at Elmley in November 2021 and there was no record that a POM had spoken to him by the time of the inspection in March. This lack of contact was exacerbated by the fact that some prisoners told us they were not aware of what they had to do in order to progress through their sentence and reduce their risk. In our survey, only 31% of prisoners said they had a custody plan. (See key concern and recommendation 1.51.)

6.11 The prison had secured additional resources to help complete initial offender assessments (OASys), which should include a sentence plan. At the time of the inspection the backlog of initial assessments had been reduced to less than 40.

6.12 Most prisoners (72%) had had an assessment that had been created or updated in the previous 12 months. Those who were still waiting for a review of their assessment to make sure it was up to date could be disadvantaged; we saw one example where a prisoner's move to open conditions was delayed for this reason.

6.13 In the sample of cases we reviewed, the quality of most was not good enough to help the prisoner progress through their sentence. For

example, the targets included did not specify what they had to do to reduce their risk. In some cases, the assessment appeared to be a copy of a previous OASys and had not been properly updated for the current sentence.

6.14 In our reviews, much of the contact between POMs and prisoners was linked to timebound tasks or simply a brief conversation to keep in touch. We saw very little evidence of structured work focused on helping prisoners to make progress. In our survey, only 45% of those who said they had a custody plan said staff were helping them achieve their targets.

6.15 In most of the cases we reviewed, the assessment included an updated risk management plan. However, records did not always evidence a handover from the POM to the community offender manager (COM) to share any relevant information to manage the prisoner's risks on release.

Public protection

6.16 Public protection arrangements remained inadequate. A small number of dedicated public protection staff screened all new arrivals to identify and record potential risks. Where information suggested a current risk, an authorisation was sought to monitor the prisoner's mail and phone calls. At the time of the inspection, over 100 prisoners were subject to such arrangements. This monitoring was carried out by staff from the operations department who said they did not have sufficient resources to complete the task. During our inspection, staff were monitoring calls that had been made over six weeks earlier and, even then it was only the calls made by some of the prisoners identified as potentially posing a current risk of harm. Staff also said they were unable to translate calls made in a foreign language. This left the prison poorly informed and potentially put victims at risk. Public protection staff told us that they had recommended monitoring be ceased for some prisoners, even though they were aware their calls had not been monitored to inform that decision. (See key concern and recommendation 1.52.)

6.17 Minutes from the interdepartmental risk management meeting (IRMM) indicated that its scope was too limited. The meeting focused on prisoners identified for management in the community under levels two and three (the highest levels) of the multi-agency public protection arrangements (MAPPA). However, the meeting did not routinely consider the potential risks posed by other prisoners who did not fit the MAPPA two and three criteria. Managers had identified this gap just before the inspection and broadened the agenda to address this. (See key concern and recommendation 1.52.)

6.18 Evidence indicated that POMs requested COMs to set MAPPA levels within appropriate timescales, although in a few cases the MAPPA alerts on prisoners' records had not been updated correctly. The quality of reports prepared by POMs for MAPPA meetings was reasonable and most included a summary of the prisoner's current risks.

Categorisation and transfers

6.19 As a local prison, Elmley had responsibility to set the initial security category for prisoners who had been sentenced, and records indicated this was generally completed on time. In the previous 12 months, almost 90% of prisoners were initially assigned category C and, where appropriate, prisoners were transferred to another establishment to serve their sentence.

6.20 The prison also completed most categorisation reviews on time, but we saw some delays due to cross-deployment of POMs; in one case, the decision to categorise a prisoner as suitable for open conditions was delayed as the POM had not completed the required OASys assessment on time.

6.21 Following the reconfiguration of the of the custodial estate, the prison was no longer designated to hold prisoners convicted of a sexual offence, as there were no interventions to meet their offending behaviour needs. However, there were still around 70 such prisoners at Elmley.

Interventions

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

6.22 There were too few opportunities for the large population of category C prisoners to undertake interventions to address their offending behaviour.

6.23 At the previous inspection, the prison offered an offending behaviour programme to help prisoners develop thinking skills to reduce their risk. Following that inspection, it had introduced an additional programme for prisoners convicted of a violent offence against an intimate partner. Before the pandemic, the prison had a target of over 50 prisoners a year to complete an offending behaviour programme, but, due to COVID restrictions and staff shortages, only six prisoners had been able to complete a programme in the previous 12 months. The prison was unable to confirm how many prisoners had been released to the community in that time without completing necessary work to reduce their offending behaviour. (See key concern and recommendation 1.51.)

6.24 The prison had recently recruited new programme facilitators and had developed credible plans to resume programme delivery in the coming months. In the meantime, too many prisoners would continue to be released without their offending behaviour needs met. In cases where it was known that a programme would not be available at the prison, POMs and COMs were not routinely including a licence condition to complete one in the community.

6.25 The prison did not have sufficient trained staff to assess high-risk prisoners to determine if they were suitable for specific programmes at other establishments. While we saw examples of POMs liaising with staff at other establishments in such cases, there was no evidence that any prisoners had transferred elsewhere to complete a programme in the previous 12 months.

6.26 We saw some isolated examples where POMS gave prisoners offending behaviour workbooks to complete on their own in cell. However, prisoners were not supported to address their offending behaviour through structured one-to-one work with their POM, and POMs told us they did not have capacity for this. (See key concern and recommendation 1.51.)

6.27 There were limited interventions for prisoners with other resettlement needs, such as finance, benefit and debt. The resettlement team could open bank accounts and obtain ID documents, and a member of staff from the Department for Work and Pensions offered some advice on claiming benefits.

6.28 Some prisoners had benefited from the support of the new employment adviser under the 'Accelerator' pilot scheme (see Glossary). Under this new initiative, the adviser had developed links with employers willing to offer jobs to prisoners on release, and this had already led to employment for a few prisoners.

6.29 As part of the same project, the prison also had an accommodation adviser who had developed links between the prison and community to identify accommodation for prisoners on release. Despite an increase in the options available to prisoners, such as supported housing for those with substance misuse issues, and concerted efforts by prison staff to, too many prisoners continued were still released without an address. In the previous six months, 68 (14%) of the 468 low- and medium-risk prisoners released were homeless and 51 went to short-term transient accommodation. The prison did not have accurate data for the accommodation outcomes of the many high-risk prisoners whose release was managed by COMs.

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.

6.30 In our survey, only 40% of those who expected to be released shortly said that someone was helping them to prepare for release. In the previous 12 months, an average of 140 prisoners a month were released to the community. This included some prisoners who were released early on HDC, although during that period 58% of prisoners eligible for HDC were released late. In some cases, this was due to delays in the community, such as awaiting a response from the

probation officer or police. However, some delays were attributable to ineffective administration by the prison.

6.31 A resettlement team in the prison met all new arrivals to assess their resettlement needs. At this point, remand prisoners were offered advice on issues such as claiming housing benefit to maintain a tenancy arrangement.

6.32 Prisoners assessed as low or medium risk were seen by the resettlement team 12 weeks before release to prepare their release plan. The release of high-risk prisoners (about half of all sentenced prisoners) was managed by the COM.

6.33 The recently introduced weekly resettlement meeting provided an opportunity for various partner organisations involved in resettlement work to progress actions to support each prisoner's release.

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 1.42: Systems to understand and respond to the causes of violence were underdeveloped. Not all violent incidents were investigated and there was little evidence that lessons were learned from those that were. In the sample of investigations we reviewed, there was usually a lack of inquiry into why the incident happened and how it could have been prevented.

Recommendation: Investigations into incidents of violence should be sufficiently thorough to understand and respond to the causes of violence, ensuring that perpetrators and victims are managed and supported appropriately.
(To the governor)

7.2 Key concern 1.43: Use of force documentation was not always fully completed and, although body-worn video cameras were readily available, too many staff failed to activate them during an incident to provide evidence and support de-escalation.

Recommendation: Leaders should make sure that staff routinely switch on body-worn cameras during use of force incidents, and that correlating documentation demonstrates appropriate de-escalation.
(To the governor)

7.3 Key concern 1.44: There were weaknesses in the governance of adjudications, segregation and security. Minutes of the relevant scrutiny meetings were brief and did not evidence enough attendance by senior managers or discussion based on the key strategic priorities. Poor assessment of data undermined the prison's understanding of some of the challenges it faced.

Recommendation: There should be effective oversight of all aspects of safety in the prison. Governance meetings should be well attended, and discussion and action should focus on key priorities in each area informed by good data analysis.
(To the governor)

7.4 Key concern 1.45: The absence of a needs analysis and clearly defined equality strategy left leaders without a sense of direction or the ability to monitor progress or assess outcomes for prisoners with protected characteristics. There was little evidence that the needs of these prisoners were understood or met. Recent consultation with protected groups lacked purpose, direction and focus.

Recommendation: The prison should have a clear strategy to identify and meet the needs of prisoners from all protected characteristic groups, ensuring there is no disproportionate treatment. (Repeated recommendation S39.)
(To the governor)

7.5 Key concern 1.46: Primary health care was challenged by staff shortfalls and had been forced to prioritise essential services. Waits for routine GP appointments had extended to over four weeks. Primary health managers frequently had to cover staffing deficits and could not always focus on the strategic aspects of their roles, which affected some aspects of governance. There were gaps in the formal managerial supervision of health staff and some mandatory training, as well as the oversight of checks on emergency equipment. Shortage of prison staff had also affected prisoner access to internal and external health appointments and other services.

Recommendation: Health care staffing should be sufficient to provide a fully functioning primary care service, including robust governance. This should incorporate effective partnership work with the prison to enable patients to attend all clinical appointments, reducing the non-attendance rates that have increased waiting times and wasted clinical resource.
(To the governor)

7.6 Key concern 1.47: Prisoners received a low quality of education, particularly in classroom and outreach settings. They did not develop substantial new knowledge and skills, and they achieved accredited qualifications at low rates.

Recommendation: Leaders should take rapid action to address the poor quality of teaching in classroom-based education, for example through improved training and quality assurance. They should make sure that prisoners have opportunities to develop substantial new knowledge and skills and, as a result, to achieve accredited qualifications at high rates.
(To the governor)

7.7 Key concern 1.48: Leaders did not use data effectively to monitor the quality of education. For example, they did not adequately track trends in recruitment, retention and achievement, and use this information to tackle weaknesses in the education provision.

Recommendation: Leaders should make more effective use of data to scrutinise the performance of learners on education courses.
(To the governor)

7.8 Key concern 1.49: Prisoners did not receive a thorough induction to education, skills and work or enough information about their education, skills and work options. Staff inhibited prisoners from making choices by discussing their confidential information in front of other prisoners. Leaders did not make sure that allocations to activities matched prisoners' career goals.

Recommendation: Leaders should make sure that prisoners benefit from a good-quality induction, carried out sensitively, that helps them to make informed choices about their work or study options, and that allocations to courses match prisoners' career aspirations.
(To the governor)

7.9 Key concern 1.50: Prisoners with learning difficulties and/or disabilities received inadequate support and support plans did not identify appropriate strategies. Prisoners who required a more in-depth assessment of their needs had to wait too long for an assessment. Too many teachers lacked the confidence to support prisoners with learning difficulties and/or disabilities effectively.

Recommendation: Leaders should make sure that prisoners with learning difficulties and/or disabilities needs receive appropriate support that enables them to make good progress in education, skills and work activities.
(To the governor)

7.10 Key concern 1.51: There was insufficient focus on, and opportunities for, sentence progression by prisoners. Contact between prison offender managers and prisoners was too infrequent, and many of the targets in prisoners' sentence plans were not specific about the work they needed to do to reduce their risk. Very few prisoners had been able to complete accredited offending behaviour programmes at Elmley or elsewhere, and POMs did not undertake one-to-one offending behaviour work with prisoners.

Recommendation: Prisoners should be able to access appropriate offending behaviour interventions to reduce their risk and progress through their sentence.
(To the governor)

7.11 Key concern 1.52: Public protection arrangements were inadequate. The scope of the inter-departmental risk management meeting was too limited to consider the risks of all high-risk prisoners approaching release. There was a six-week backlog of phone calls made by high-risk prisoners waiting to be monitored.

Recommendation: Leaders should enforce robust arrangements to protect the public by identifying and managing effectively the risks posed by all high-risk prisoners in custody and before their release.
(To the governor)

Recommendations

7.12 Recommendation 3.22: A senior prison manager should investigate fully all use of batons and PAVA to make sure that use is proportionate and that lessons are learned.
(To the governor)

7.13 Recommendation 3.39: All intelligence reports requiring a cell search should be acted on promptly.
(To the governor)

7.14 Recommendation 3.40: HMPPS should review security incident reporting in Elmley to make sure that all incidents are categorised accurately.
(To HMPPS)

7.15 Recommendation 4.76: The transfer of patients to hospital under the Mental Health Act should take place within agreed Department of Health timescales. (Repeated recommendation 2.78.)
(To the governor)

7.16 Recommendation 4.93: Stock medicines should be audited and reconciled at regular intervals to identify anomalies and investigate them promptly.
(To the governor)

7.17 Recommendation 4.94: Prison officers should consistently monitor and manage medication administration queues to reduce the opportunities for bullying and diversion, and to maintain patient confidentiality at the hatch. (Repeated recommendation 2.95.)
(To the governor)

7.18 Recommendation 5.8: Gym use should be monitored and underrepresented groups encouraged to participate in physical education and fitness provision.
(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 2019, work to support prisoners in their early days was reasonably good. Levels of violence were lower than in comparable prisons but had risen, and one in four prisoners still felt unsafe. Intervention plans were in place for the most violent prisoners and the most vulnerable victims of violence. Too many incidents were not investigated, and the quality of investigation was inadequate. The incentives and earned privileges (IEP) policy was not used effectively to motivate positive behaviour, and staff often did not challenge low-level poor behaviour. Gaps in the governance of the use of force made it difficult to conclude that all force was justified. Segregation was well managed. Despite significant drug use the prison had no effective supply reduction strategy. Care for prisoners in crisis was reasonably good. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

The prison's investigations into incidents of violence should be comprehensive and thorough to ensure that the perpetrators and victims of violence are managed and supported, and to understand the causes of violence. (S35)
Not achieved

Managers should develop and monitor an effective drug supply reduction strategy. (S36)
Achieved

Recommendations

Decisions to strip search prisoners should be supported by an individualised risk assessment. (1.6)
Not achieved

Prisoners who do not speak English should have access to induction information in a language they understand. (1.7)
Not achieved

Staff should use the incentives and earned privileges (IEP) scheme systematically and fairly to encourage positive behaviour. (1.17)
Not achieved

Quality assurance of adjudications should provide regular feedback for adjudicators and segregation unit staff to encourage continuous improvement. (1.21)
Achieved

There should be effective quality assurance processes to ensure that the use of force has been legitimate, necessary and proportionate. (1.27)
Partially achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2019, relationships between staff and prisoners were reasonably good. However, managers did not set and maintain sufficiently high standards for staff to follow. Prisoner behaviour and cleanliness on some units were poor. The quality and quantity of food were inadequate. New consultation arrangements were promising and there was good use of peer support. Management of the application process was weak. Responses to complaints had improved but there was insufficient analysis and institutional learning. Equality work had improved but support for foreign national prisoners was inadequate. Prisoners had problems in accessing some health services but the quality of health care was reasonable. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

Managers and staff should be visible and actively engage with prisoners during periods of unlock to enforce rules and promote safety. (S37)
Achieved

High standards of cleanliness should be set and maintained across the prison. (S38)
Not achieved

The prison should have a clear strategy to identify and meet the needs of prisoners from all protected characteristic groups, ensuring there is no disproportionate treatment. (S39)
Not achieved (recommendation repeated, 1.45)

Prisoners should be able to access internal and external health appointments promptly and within community-equivalent waiting times. (S40)
Not achieved

Recommendations

The prison should ensure that prisoners have a sufficient range and quantity of food that meets all appropriate food safety standards. (2.18)
Achieved

All prisoners should be aware of opportunities to engage in consultation, and the outcomes from consultation should be communicated effectively. (2.24)
Not achieved

The prison should ensure that prisoners do not have to make repeated applications for services. (2.25)
Not achieved

The transfer of patients to hospital under the Mental Health Act should take place within agreed Department of Health timescales. (2.78)
Not achieved (recommendation repeated, 4.76)

The prison should work in partnership with substance misuse service providers and consult with service users to develop a more structured environment on the drug treatment unit that supports an ethos of recovery and well-being. (2.86)
Achieved

Prison officers should consistently monitor and manage medication administration queues to reduce the opportunities for bullying and diversion, and to maintain patient confidentiality at the hatch. (2.95)
Partially achieved (recommendation repeated, 4.94)

Purposeful activity

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

At the last inspection, in 2019, time out of cell was insufficient for too many prisoners. Leadership and management of learning, skills and work required improvement. Partnership working through the new learning and skills contract was promising although it was too early to measure its effectiveness on outcomes. There were sufficient activity spaces for every prisoner but attendance and punctuality still required improvement. Activities for vulnerable prisoners remained severely limited. Collaborative work with employers was good and there were plans to address the shortfall in vocational training places. The quality of teaching, learning and assessment required improvement. Prisoners' personal skills and development were not always recognised, and they did not achieve well in some important areas. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendation

Prisoners should be enabled to participate in a range of vocational training and meaningful purposeful work to equip them with the skills they need to move into further education, training and/or employment on release. (S41)
Partially achieved

Recommendations

All prisoners should have the frequent access to association and exercise in the open air. (3.8)
Achieved

All prisoners should have access to regular physical education sessions. (3.9).
Not achieved.
Managers should eliminate the weaker practice in teaching and learning and improve the quality so that it is at least good. (3.27)
Not achieved

Staff should ensure that all prisoners attend their allocated activity and arrive on time. Staff should be made aware promptly of the reasons for prisoner absences, and take action to record these accurately and deal with unauthorised absences. (3.32)
Achieved

More prisoners should gain achievements in English and mathematics qualifications. (3.36)
Not achieved

Rehabilitation and release planning

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

At the last inspection, in 2019, there had been some improvements to help prisoners maintain contact with their families. The strategy to manage rehabilitation and release planning was not based on a prisoner needs analysis and there was no action plan to drive improvements. A lack of resourcing had led to a significant backlog of OASys (offender assessment system) completions and inadequate offender management for many prisoners. Despite improvements to home detention curfew (HDC) processes, too many eligible prisoners were not released on time. Transfers of prisoners to progress their sentences were too slow. Multi-agency public protection arrangements (MAPPA) were well managed, but there were significant weaknesses in public protection monitoring. The community rehabilitation company (CRC) provided a good service, although a third of prisoners were released from Elmley with nowhere to live. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

The reducing reoffending strategy should meet the needs of the specific population at Elmley to ensure that interventions are appropriate. (S.42)
Not achieved

Offender supervisors and keyworkers should have regular good quality contact with prisoners to help drive sentence progression. (S.43)
Not achieved

Public protection procedures should be given urgent and sustained attention to ensure that prisoners' risks are managed effectively. (S.44)
Not achieved

There should be an urgent and coordinated review of accommodation available for prisoners released from Elmley, and relevant action taken to provide suitable sustainable accommodation on release. (S.45)
Not achieved

Recommendations

The prison should ensure that visiting arrangements maximise the opportunity for all prisoners to maintain family ties, including visits starting on time. (4.7)
Achieved

Offender supervisors who manage high-risk and sex offence prisoners should receive sufficient training and professional supervision. (4.20)
Not achieved

Prisoners should have an up-to-date OASys assessment. (4.21)
Not achieved

Release on temporary licence (ROTL) should be used to support resettlement with appropriate prisoners, subject to risk assessment. (4.29)
Not 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:

Charlie Taylor	Chief inspector
Deborah Butler	Team leader
Hindpal Singh Bhui	Inspector
Sumayyah Hassam	Inspector
Deri Hughes-Roberts	Inspector
Lindsay Jones	Inspector
Ali McGinley	Inspector
David Owens	Inspector
Dionne Walker	Inspector
Rahul Jalil	Researcher
Amilcar Johnson	Researcher
Emma King	Researcher
Isabella Raucci	Researcher
Sophie Riley	Researcher
Maureen Jamieson	Lead health and social care inspector
Karen Wilson	Health and social care inspector
Noor Mohamed	Pharmacist
Gary Turney	Care Quality Commission inspector
Carolyn Brownsea	Ofsted inspector
Diane Koppit	Ofsted inspector
Rebecca Perry	Ofsted inspector
Saul Pope	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/

Accelerator project
The reducing reoffending Accelerator project supports the prime minister's crime and justice taskforce targets. Specially selected staff at 16 prisons design, implement and test new ways to support people in prison, in relation to education, health and substance misuse, employment and accommodation. The overall aim is to help them desist from crime on release and to rebuild their lives.

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.

Independent adjudicator
The governor can refer a serious allegation of prisoner ill-discipline to an independent adjudicator, a district judge, who has the power to impose additional days, up to 42, to their sentence. More serious matters can be referred to the police.

Itemiser
A machine to test for the presence of psychoactive substances.

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.

Listeners
Prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners.

Offender management in custody (OMiC)
The Offender Management in Custody (OMiC) model, being rolled out across the closed male prison estate, entails prison officers undertaking key work sessions with prisoners (implemented during 2018–19) and case management, which established the role of the prison offender manager (POM) from 1 October 2019. On 31 March 2021, a specific OMiC model for male open prisons, which does not include key work, was rolled out.

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.

Reverse cohort unit (RCU)
Unit where newly arrived prisoners are held in quarantine for between seven and 10 days.

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 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.

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/

Printed and published by:
Her Majesty's Inspectorate of Prisons
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