Report on an unannounced inspection of

HMP Feltham B

by HM Chief Inspector of Prisons

3–13 January 2023

Contents

Introduction

Feltham B is a YOI in west London for 18–21-year-olds that shares a site with the neighbouring under-18s facility. It contained 307 prisoners at the time of our inspection, a capacity that was reduced by the closure of three units. In the next year the population is expected to increase, with the maximum age of prisoners rising to 24.

The last inspection, in 2019, was one of the most positive of recent years: we judged safety, respect, and rehabilitation and release planning to be reasonably good. Inspectors were, however, critical of the quality of purposeful activity, which they rated as poor.

The findings in this inspection were dominated by the high levels of violence that were affecting the provision of almost every aspect of the jail. The key statistic from our survey was that 27% of prisoners told us they felt unsafe, compared with 14% last time. Many were afraid to go to education, where the attendance rate was a paltry 60%, and inspectors found 38% of prisoners locked in their cells during our checks and only 25% off the wing in activities.

Although the quality of teaching was good in some areas, prisoners were choosing to remain on the wing and accept a sanction for non-attendance because they were scared to mix with other prisoners. It was disappointing that leaders were not aware of the extent to which the regime had slipped.

There had been dramatic increases in violence when pandemic restrictions were lifted last year. Since then, staff had worked hard to reduce levels, but they remained much higher than in similar prisons. Relationships between officers and prisoners were generally good and poor behaviour on the wings was effectively challenged. Too often, however, officers had to deal with planned assaults between groups of prisoners that had led to some serious injuries.

The prison had fallen into the habit of maintaining extensive keep-apart lists aimed at preventing prisoners in conflict with each other from mixing. Although these arrangements can be necessary in extreme cases where, for example, a relative of one prisoner has been the victim of a serious crime from another, our experience is that prisons with the most keep-aparts are often the most violent. New arrivals were placed in a group with other prisoners who arrived on the same day. This led to group affiliation that itself became a cause of violence as different groups came into conflict, even though some of these prisoners had been mixing safely at their previous prison. By doing this, the prison was compounding gang-like behaviour and creating another layer of potential conflict on top of what prisoners were bringing in from the outside.

Delays in police investigations and decisions to charge meant that some of the most serious violence was not being dealt with in a timely way and was impacting on the possibility of parole for some prisoners. Improved liaison between the police and the prison would help leaders to reduce violence.

Staff shortages in the London probation services and in the prison were hampering preparation for release with limited accredited programmes and risk management meetings not taking place early enough.

Since her arrival last year, the governor had been active and visible around the jail; she had a developed a clear self-assessment that broadly reflected the findings of this inspection and had set three clear priorities to reduce violence and improve staff capability. She also benefited from having some strong, experienced senior leaders who were working to build up the capability of staff across the jail.

Although the reduction in scores on this inspection are disappointing, staff at Feltham have much to be proud of, with some impressive work highlighted in this report. Bearing down on the high levels of violence will need to be the key priority that will lead to improvements elsewhere in the jail, particularly in getting prisoners into the education and training that will help them to avoid reoffending on release.

Charlie Taylor
HM Chief Inspector of Prisons
January 2023

What needs to improve at HMP Feltham B

During this inspection we identified 12 key concerns, of which four should be treated as priorities. Priority concerns are those that are most important to improving outcomes for prisoners. They require immediate attention by leaders and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

1. **Levels of violence were too high and prisoners had poor perceptions of their safety.** Leaders, staff and prisoners were over-reliant on keeping prisoners apart rather than addressing underlying causes of violence. Investigations into incidents were often delayed and sometimes of poor quality.

2. **Too few prisoners had access to education, skills and work, based on their needs.** Leaders did not ensure that enough prisoners were allocated to the available activity spaces.

3. **The attendance and punctuality of prisoners to activities were poor.** Leaders should ensure that the number of prisoners attending activities increases.

4. **Leaders and managers had limited oversight of the regime on residential units.** There were regular delays in the core day. There was too little association and exercise which was inconsistent across wings.

Key concerns

5. **The use of segregation was high, conditions on the unit were poor and the regime was limited.**

6. **Prisoners who were on ACCT (assessment, care in custody and teamwork) plans did not feel cared for by staff.** Care maps did not always reflect concerns raised by prisoners and family engagement was not used adequately to support prisoners.

7. **Prisoners did not receive medication in a clinically appropriate environment and best practice guidelines for patient safety, confidentiality and decency were not met.**

8. **Leaders did not investigate data that indicated differences in treatment or access to the regime for prisoners with protected characteristics.**

9. **Prisoners did not have access to enough accredited courses in industries that would help them gain employment once released.** Leaders and managers should ensure that prisoners at work receive appropriate training for their roles and gain accredited qualifications where appropriate.

10. **The number of prisoners who achieved qualifications was too low.** Leaders and managers should improve the quality of teaching in order to raise the levels of achievement in the prison.

11. **Staffing pressures in the OMU and resettlement teams were also present in many of the community probation teams that Feltham worked with, which affected prisoner progression and release planning.** This contributed to a backlog of prisoner OASys assessments, delays in some home detention curfew releases and often limited contact with prisoners.

12. **Release planning was not carried out consistently and too many prisoners did not have timely preparation and support before their release.**

About HMP Feltham B

Task of the prison/establishment
Category C training and resettlement prison for convicted prisoners aged 18 to 21 years

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 307
Baseline certified normal capacity: 528
In-use certified normal capacity: 388
Operational capacity: 322

Population of the prison
- 270 new prisoners received during 2022
- 60 foreign national prisoners
- 80% of prisoners from black and minority ethnic backgrounds
- 20 prisoners released into the community each month
- 58 prisoners receiving support for substance misuse

Prison status (public or private) and key providers
Public

Physical health provider: Central and North-west London NHS Foundation Trust (CNWL)
Mental health provider: CNWL
Substance misuse treatment provider: CNWL
Prison education framework provider: Novus
Escort contractor: Serco

Prison group/Department
Youth Custody Service

Prison Group Director
Heather Whitehead

Brief history
HMYOI Feltham B was previously a remand centre for young adults up to 21 years of age, serving the London and South-east area. After a poor HMIP inspection in 2015 with recommendations from the Chief Inspector to HMPPS, Feltham B changed designation to hold sentenced young adults which is still the case. A vast majority of the population are from the London area with an average sentence length of three to four years.

Short description of residential units
Feltham B has 10 residential units, two of which are currently offline awaiting refurbishment (Mallard and Nightingale). One unit, Teal, is ready for occupation.

Most units have an A and B side with 28 residents on each side.

Kingfisher serves as the first night and induction unit.

Name of governor/director and date in post
Natasha Wilson, April 2022 –

Changes of governor/director since the last inspection
Emily Martin, September 2018 – March 2022

Independent Monitoring Board chair
Jane Shalders

Date of last inspection
July 2019

Section 1 Summary of key findings

Outcomes for prisoners

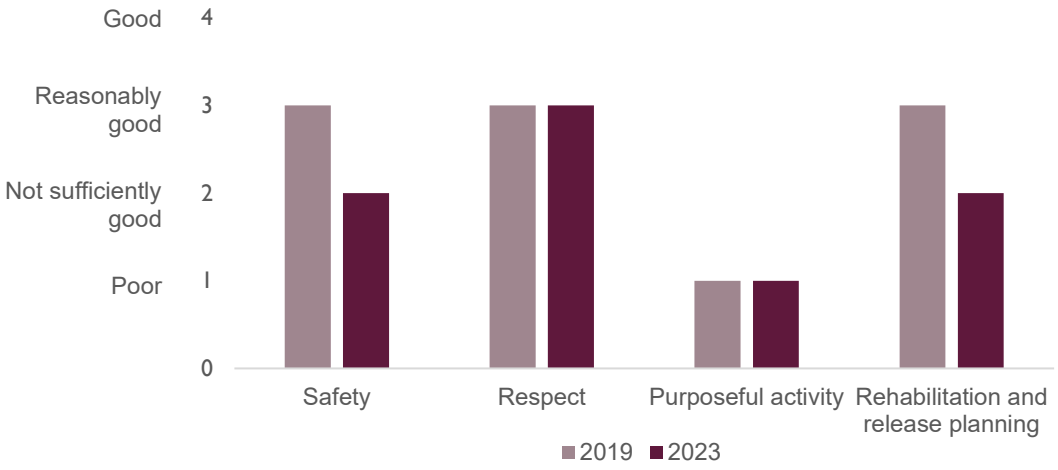
1.1 We assess outcomes for prisoners against four healthy prison tests: safety, respect, purposeful activity, and rehabilitation and release planning (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.2 At this inspection of HMP Feltham B, we found that outcomes for prisoners were:

- not sufficiently good for safety
- reasonably good for respect
- poor for purposeful activity
- not sufficiently good for rehabilitation and release planning.

1.3 We last inspected HMP Feltham B in 2019. Figure 1 shows how outcomes for prisoners have changed since the last inspection.

Figure 1: HMP Feltham B healthy prison outcomes 2019 and 2023



Progress on key concerns and recommendations from the full inspection

1.4 At our last inspection in 2019, we made 24 recommendations, 14 of which were about areas of key concern. The prison fully accepted 21 of the recommendations and partially (or subject to resources) accepted two. It rejected one recommendation.

1.5 At this inspection we found that one of our recommendations about areas of key concern had been achieved and 13 had not been achieved. No recommendations made in the area of safety had been achieved. One recommendation in the area of respect had been achieved, with three not achieved. Five recommendations for purposeful activity and two for rehabilitation and release planning had

not been achieved. For a full list of the progress against the recommendations, please see Section 7.

Notable positive practice

1.6 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.

1.7 Inspectors found two examples of notable positive practice during this inspection.

1.8 Night staff introduced themselves to new prisoners, provided them with reassurance and encouraged them to raise concerns so that they could be swiftly resolved. (See paragraph 3.9)

1.9 Leaders had recognised the increase in prisoners with longer determinate sentences. A regular forum piloted on one wing had helped them to understand their sentences and feedback from these prisoners had been used to plan support for others with similar sentences. (See paragraph 6.17)

Section 2 Leadership

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

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

2.2 A new governor had been appointed eight months before our inspection and the transition had been managed well by the Youth Custody Service, avoiding the uncertainty that often comes with a change of leader.

2.3 The new governor's self-assessment report presented an accurate assessment of outcomes for prisoners and the substantial challenges faced at the prison. There were high levels of conflict among prisoners. Some of this involved entrenched gang related disputes, but conflict had also been exacerbated by the restrictions imposed during the COVID pandemic. The population had been split into small groups which created more conflict as the groups antagonised each other through locked doors and had little opportunity to resolve the ensuing disagreements.

2.4 The governor was visible around the establishment and had set appropriate priorities which focused on reducing violence, improving purposeful activity and developing staff capability. We found some recent signs of progress with decreasing levels of violence and increasing staff capability, but there was still some way to go to improve access to and the quality of purposeful activity.

2.5 It was positive that leaders expected prisoners to mix in classrooms and workshops so that education and work could be delivered that was appropriate for the needs and aspirations of the population.

2.6 There was considerable activity to address violence, a more coherent plan was needed to address prisoners' justifiably poor perceptions of safety and to reduce the number of prisoners who were kept apart from each other to reduce conflict.

2.7 It was concerning that leaders and managers did not have an accurate understanding of the regime being delivered on residential units. Key elements of the regime, including exercise, association and showers, varied from wing to wing. Exercise periods were too often short and association was delivered on just two weekdays a week, which was less frequent than leaders expected.

2.8 Continuous improvement was undermined, in part by poor recording of meetings. Minutes of strategic meetings that we reviewed, including

senior management team meetings, were poor or missing, rendering the tracking of actions and decisions impossible.

2.9 The governor had appropriately kept three units closed which had improved staffing levels. The population had been increasing over the previous year and, if that were to continue, the governor would need capital investment from HMPPS to bring the mothballed units to a suitable standard before they reopened.

2.10 Senior leaders and middle managers made sure that living conditions were of a good standard across the prison. Communal areas were clean and tidy and cells were generally well equipped and free of graffiti.

2.11 Prison and health care leaders had not addressed longstanding problems with the administration of medicines. There was still no appropriate location for the administration of medication which was carried out from a trolley on each wing.

2.12 National HMPPS leaders had not ensured that there were adequate staff for community probation in London. This undermined efforts by managers at Feltham, who also had staffing difficulties, to progress prisoners.

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 An average of eight prisoners were received each week. Most were from London but sometimes from further afield.

Reception

3.2 Reception was calm and staff were welcoming, although holding rooms, toilets and communal areas were dirty. There were no prisoner peer mentors to meet and greet new prisoners in reception and there was very little information for prisoners to read while they waited to be seen by staff.

Reception toilet

3.3 Routine strip-searches were not carried out and prisoners were searched by a body scanner on arrival. The reception process was swift. In our survey, two-thirds of prisoners said they spent less than two hours in reception. Welfare interviews and an initial health care assessment took place on the induction wing.

3.4 All new prisoners were able to buy either a vape or confectionery pack to last until they received their first order from the prison shop. Although, they invariably missed their first order if they arrived on or after canteen day and some prisoners had to wait up to two weeks, which increased the risk of borrowing and debt.

3.5 Personal property arriving with prisoners was sometimes issued on the day of arrival but more often on the following day after it had been searched by reception staff. The property that prisoners were allowed to have in possession at Feltham B was not consistent with other prisons. For example, we observed one prisoner arriving with shorts and another with a battery-operated LED wall light that he had bought at his previous prison, both of which were disallowed, although we observed similar lights in some cells. Leaders were unable to explain the inconsistent application of rules which was frustrating to many prisoners whom we spoke to.

3.6 There were delays in receiving property that had been posted. Reception staff worked hard to clear the backlog of property but at the time of the inspection there was a backlog of 65 applications to process.

3.7 Kingfisher, the induction unit, had recently been refurbished. It was clean and bright and cells for new arrivals were well prepared.

Induction staff were enthusiastic and caring and staff showed each prisoner their cell while helpfully re-checking that everything required for the first night was present and in working order before moving on to conduct the initial safety welfare interview in a private room. Prisoners were then seen in private by a nurse on Kingfisher. Both interviews focused appropriately on safety and concerns were shared with relevant departments.

First night cell

3.8 In our survey, all prisoners said they had received an induction at the prison which was excellent. Induction started on the following day and lasted 10 days. Useful information was imparted, but some elements were irrelevant and needed review. In our survey, 55% of prisoners said that the induction covered everything they needed to know.

3.9 Leaders ensured that welfare checks took place during a prisoner's first night in custody. During our night visit we observed staff unhurriedly introducing themselves to new prisoners, asking if they had any concerns or needs and responding promptly when support was required. This helped to alleviate anxiety and settle prisoners down in a calm environment.

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

3.10 Prisoners' perceptions of safety were poor. In our survey, 27% said they felt unsafe at the time of our inspection compared with 12% at similar prisons and 14% at the previous inspection, and 54% said they had felt unsafe at some time. Many prisoners told us that they lived in fear of being assaulted.

3.11 Rates of violence against prisoners and staff had increased since the last inspection and were higher than in other prisons holding young adults. During the previous 12 months, there had been 283 assaults among prisoners and 53 assaults on staff. Seven per cent of all incidents had been serious. We viewed footage of incidents which showed that staff were swift to intervene when violence occurred and undoubtedly prevented prisoners from being seriously injured.

3.12 Leaders had put in place several initiatives to address the levels of violence. A conflict resolution team had been introduced in March 2022, since when 103 prisoners had completed conflict resolution and had not had any further conflict with each other. There were plans to expand the initiative to enable practitioners to address group conflict. In August 2022, a 'reset week' had been held where managers conducted focus groups with prisoners to improve their understanding of violence. This had resulted in a reset education pathway for prisoners who had been involved in conflict in education or work. In December 2022, a safety event had been organised and a substantial quantity of information had been collected from interviews and focus groups. Leaders were using these data at the time of the inspection to draw up a revised strategy and the rate of violent incidents was steadily reducing.

3.13 Conflict between groups was a key cause of violence in the prison. The population included prisoners who had been in conflict outside the prison, largely through gangs and geographical areas. Since the opening up of the regime after the pandemic, internal disputes between different residential units had also developed. A gang database identified known and potential conflict among prisoners and, at the time of our inspection, there were 300 keep-aparts involving 175 prisoners. Leaders, staff and prisoners were over-reliant on the keep-apart system which was preventing the delivery of the regime and had not, ultimately made the prison safer. The system was becoming unsustainable given the increasing population at the prison.

3.14 A range of meetings were held to discuss violence, including a weekly safety intervention meeting, monthly safety meeting, conflict resolution meeting and a recently introduced safety analysis meeting. These were well attended and the monthly analysis was reasonable. While the meetings were having some impact, and levels of violence were reducing, the data were not sufficiently detailed to determine fully the causes of violence or to understand the impact of actions taken.

3.15 Challenge, support and intervention plans (CSIPs, see Glossary) were inconsistent. Investigations into violence were sometimes poor and a third of investigations during 2022 had taken too long. The process to open each CSIP took weeks after the incident had occurred. Most care maps were good, but reviews did not always take place. Prisoners on a CSIP were aware of their plan, but staff managing prisoners had no knowledge of them.

3.16 Victims of violence were seen by the safer custody team and given additional support. Most CSIPs were opened following violent incidents and were rarely opened to support victims or to challenge low-level behaviour such as bullying.

3.17 We observed staff challenging prisoners appropriately for not following unit rules. Prisoners who had been held in other establishments found this confusing and told us they felt as if they were treated like children, but the rules were displayed in each residential unit and we found them to be appropriate. They were enforced consistently, which was good and better than we see in other prisons.

3.18 We found two prisoners self-isolating, but there was no mechanism for routinely identifying and monitoring the welfare of prisoners who were self-isolating or to make sure that they received an adequate minimum regime.

3.19 The incentives scheme had been revised after consultation in June 2022. Incentives were focused on priorities for the prison, for example there were specific rewards for prisoners who attended work for three months and were not involved in violence. However, in our survey, only 46% of prisoners said the scheme encouraged them to behave well and prisoners told us there were not enough incentives to improve their behaviour.

Adjudications

3.20 During the previous 12 months, there had been 2,676 adjudications, which was more than at our last inspection. Charges were laid appropriately for offences including violence and contraband but the police had a backlog of 118 adjudications to address dating back over a year. The lack of consequences for the most serious offences undermined behaviour management procedures.

3.21 The deputy governor conducted monthly quality assurance checks on adjudications and fair treatment of prisoners. In the sample that we examined, adjudicators enquired appropriately into the charges laid

and the awards given to those found guilty were proportionate to the offence committed.

Use of force

3.22 The rate of use of force was higher than at our previous inspection. During the previous 12 months, force had been used on 852 occasions, with the majority relating to the high levels of violence.

3.23 The use of PAVA (incapacitant spray) had been introduced in March 2022 and had been used during 42 incidents, which was very high in comparison to other prisons. Batons, another high-level intervention, had also been used on 28 occasions and prisoners had been struck on seven occasions. The governance of these interventions was carried out by the governor or deputy governor and was robust.

3.24 The sample of footage that we examined involved a wide range of incidents, including the use of PAVA and batons. In these cases, the force used had been justified and proportionate and learning points had been identified.

3.25 In August 2022, leaders had rolled out the more up-to-date body-worn video cameras, which had considerably improved the rate of incidents recorded. There was footage of 86% of incidents, although staff did not always turn the cameras on to capture the build-up to incidents.

3.26 In our survey, 33% of prisoners said they had been physically restrained by staff in the last six months. It was positive that 68% of prisoners said that someone had come to talk about it afterwards compared with 35% at similar prisons.

3.27 Oversight of use of force was good. All incidents were reviewed at a weekly meeting and a good range of information was discussed at a well-attended monthly meeting. Actions were taken following incidents where required and learning was shared. During the previous 12 months, 79% of staff had received refresher training and 84% had received a new personal protection training package. The quality of the use of force reports that we viewed was good and only a very small number of records were outstanding.

Segregation

3.28 The use of segregation was high and had increased since the last inspection. In our survey, 39% of prisoners said they had spent one or more nights in segregation within the last six months. Most stays were relatively short at around four days.

3.29 While prisoners held in the segregation during the inspection were positive about their treatment in our survey only 37% of those who had spent time in segregation said that they had been treated well by staff, compared with 83% at similar prisons. Leaders were unaware of the reasons behind these negative views.

3.30 We reviewed segregation records, particularly those held on rule 49 (good order and/or discipline), which showed that reintegration planning started on entering segregation. Prisoners we spoke to were aware of their plans and some had a copy, which was good. Different managers chaired the reviews, which could lead to inconsistency for prisoners.

3.31 Living conditions were poor on the unit. Cells were reasonably well equipped and the showers had been refurbished, but they had no electricity, the unit was dark and dismal, the roof had leaks and the exercise yards were stark.

Segregation unit

Segregation unit exercise yard

3.32 The daily regime for prisoners was too limited. They were offered up to an hour in the open air and a daily shower. Some activities were organised once a week such as kinetics, well-being and the gym, which was a slight improvement since the last inspection.

3.33 Oversight of segregation was adequate. A range of data were discussed at monthly meetings, but when disproportionality was identified it was not investigated well enough.

3.34 There had been no use of unfurnished accommodation since our last inspection and the cell had been repurposed into a small gym area.

Segregation small on-unit gym

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.

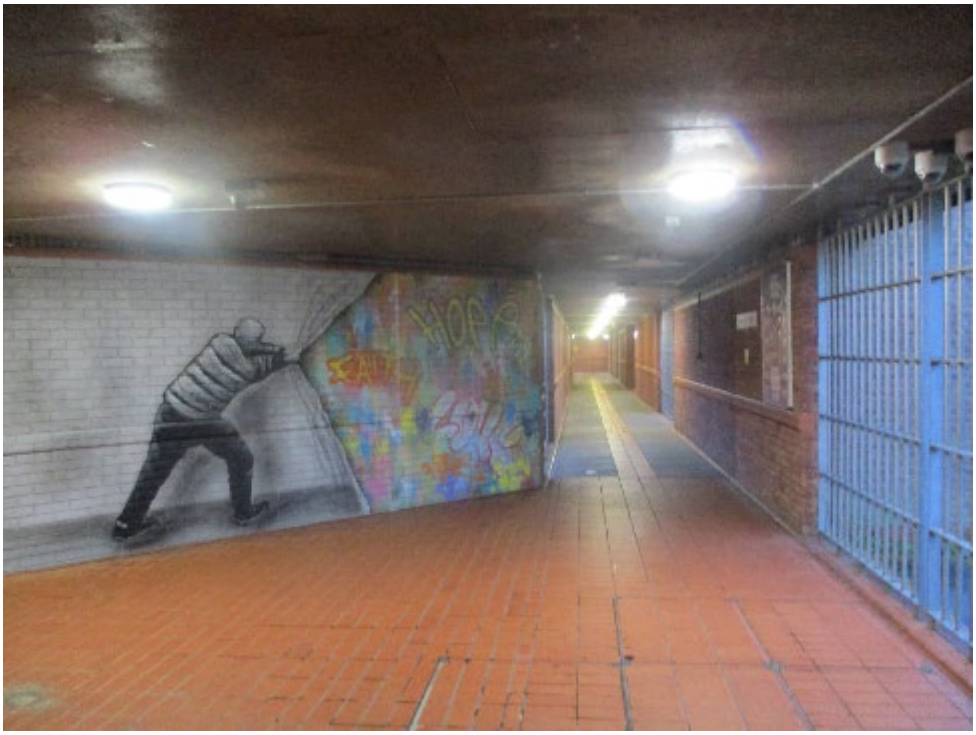
3.35 There was a good flow of intelligence into the security department, with an average of 350 information reports a month which enabled staff to identify emerging threats. Information sharing with other departments was reasonable and a recently introduced meeting between safety and security analysts was a good initiative. However, actions prompted by individual intelligence reports did not always take place, for example targeted searching.

3.36 Leaders responded to wider threats and had recently carried out a lock-down search of a wing, based on a high volume of intelligence. This had resulted in several finds, including mobile phones and drugs.

3.37 There had been some improvements to physical security since our last inspection and the prison now had a body scanner and drug itemiser.

There was limited CCTV coverage in education, but leaders had given teachers body-worn video cameras to mitigate this weakness.

3.38 Movement to activities was slow. The route to activities was well supervised, but each unit moved individually and it could take up to half an hour to move a small number of prisoners.



A walkway

3.39 Most searching arrangements were proportionate, but we observed searches that were not conducted effectively when prisoners were leaving residential units. The routine strip-searching of prisoners on release was excessive.

3.40 Leaders had good working relationships with the police and other agencies to help manage prisoners from serious and organised crime groups or those who posed a threat of extremism. However, they did not receive effective support with prosecutions for serious offences that had occurred at Feltham (see paragraph 3.20).

3.41 In our survey, only 7% of prisoners said that it was easy to get illicit drugs. Mandatory drug testing (MDT) had been reasonably consistent during the previous 12 months when 288 tests had been taken, only 10 of which had returned positive. This represented a positive rate of 3.5%, which was low. However, effective use was not made of suspicion testing, and only five suspicion tests had been completed in the same period, all of which were positive.

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

3.42 There had been 147 recorded self-harm incidents in the previous 12 months. While rates were similar to comparable prisons, they had increased since the last inspection.

3.43 Serious self-harm was rare. One incident had required hospital treatment but the local investigation into it was weak and lacked enquiry into the prisoner's perspective of what had led to the incident.

3.44 The safety strategy did not focus on reducing self-harm. The safety committee held regular well-attended meetings but predominantly concentrated on violence at the prison and actions to reduce self-harm were vague and not timebound. Relevant data were discussed but had not been used by leaders to inform their understanding of the causes of self-harm and develop a bespoke action plan.

3.45 All prisoners on open ACCTs (assessment, care in custody and teamwork case management of prisoners at risk of suicide or self-harm) were discussed at the weekly safety intervention meeting (SIM), However this meant that those prisoners who needed more significant multi-disciplinary support, such as men who repeatedly self harmed, were not discussed in enough detail. Managers were, therefore, unable to determine if support plans were effective or to direct support where it was most needed.

3.46 During the previous 12 months, 100 ACCTs had been opened and eight were open at the time of our inspection. ACCT processes were reasonably good, reviews were conducted on time and nurses attended frequently. In our survey,18% of prisoners said they had been on an ACCT but only half of them said they had felt cared for. Actions were not always care orientated and opportunities such as involving family members were sometimes missed. Prisoners we spoke to said they felt that staff were supportive, but reviews very seldom resolved their concerns. ACCT care maps that we looked at did not always reflect the concerns raised by prisoners during reviews.

3.47 During the previous 12 months, constant supervision had been used four times for an average of two to three days. No prisoners were on constant supervision at the time of our inspection. Prison records showed that the regime for prisoners subject to constant supervision consisted of little more than observation through a gated cell by a member of staff for most of the day and night. Prisoners who had recently been on constant supervision confirmed this. Leaders

undertook to find ways to engage prisoners on constant supervision in a more constructive and caring way.

3.48 The service that Listeners provided (prisoners trained by the Samaritans to provide emotional support to fellow prisoners) was very poor. There was just one trained Listener in the prison and there was no record of how often he was requested. Leaders were conducting a recruitment campaign for Listeners to address this.

3.49 Anti-tear clothing had not been used at all during the previous 12 months and most staff had received training in suicide and self-harm awareness.

Protection of adults at risk (see Glossary)

3.50 The adult safeguarding policy was up to date but lacked clarity on how to make a safeguarding referral. There had been several recent leadership changes and most staff were confused about who the prison safeguarding lead was.

3.51 Many staff we spoke to did not know what would meet the threshold of a safeguarding referral or how to report it. There had been eight safeguarding referrals to the local authority during the last 12 months. Leaders had been tracking the outcomes of referrals and the deputy governor had established good links with the local safeguarding partnership board.

Section 4 Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

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

4.1 In our survey, 72% of prisoners said that staff treated them respectfully and this was reflected in our conversations with prisoners. We saw examples of professional, decent interactions between staff and prisoners which showed that staff knew the prisoners in their care reasonably well.

4.2 Key working was good. In our survey, 95% of prisoners said they had a key worker compared with 65% at similar prisons. Records that we examined contained regular, detailed entries which showed that staff spent time getting to know to prisoners during key work sessions. They used a list of questions to generate interest and conversation and promote better engagement in these sessions. Prisoners told us they felt staff wanted to talk and had time to spend with them during key work.

4.3 Key work was well embedded. Each officer held key work sessions with the same three prisoners each week and staff were given half a day each week to complete these sessions. Staff said they had meaningful conversations with prisoners during key work sessions and felt that this benefited their relationships.

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

4.4 Communal areas were clean and tidy and there was plenty of equipment such as pool and table tennis to occupy prisoners on the wings. Access to the showers was not frequent enough because of restrictions in the regime (see paragraph 5.2). In our survey, only 78% of prisoners said they could have a shower every day compared with 97% in similar prisons. The showers had been refurbished and were

considerably improved since our last inspection, but mould caused by poor ventilation continued to be a problem.

Refurbished showers

4.5 Cells were in good condition with little graffiti. Wing managers were aware of the graffiti that was present and had plans to remove it. Cells had appropriate furniture and all double cells were designed to hold two prisoners.

A typical cell

4.6 Prisoners were able to keep their cells clean and had good access to clean bedding. Nearly all cells had toilet seats, apart from Kingfisher wing. Porcelain toilets were clean and few were scaled, but the older stainless steel units were in poor condition and some were corroded.

4.7 Double cells had private toilets but there was no screen in single cells leaving prisoners visible to anybody looking through the observation panel in the cell door.

4.8 Exercise areas were poor. Some were overgrown and contained equipment that did not work.

4.9 Roofs leaked in several places, including into a few cells which were damp with mould. Most but not all of these cells had been taken out of use. We observed prisoners serving the hot evening meal from a servery with a leak directly above the food and trying to divert the drips away from the meal.

4.10 Cell call bells were not monitored and leaders did not know the average time it took for staff to answer them. In our survey, 25% of prisoners said that their cell bells were answered within our expectation time of five minutes.

Residential services

4.11 Prisoners' perceptions of the food were good and we heard very few complaints. The kitchen produced a healthy selection of meals on a four-week rota and regularly consulted prisoners to inform any changes. The meals that we observed being cooked were nutritious and varied. Suitable cultural and medical diets were catered for.

Evening meal

4.12 The size of the portions had improved. In our survey, 62% of prisoners said they always had enough to eat at mealtimes compared with 40% at our previous inspection.

4.13 Prisoners employed in the kitchen had not completed food safety or food handling courses because the instructor had not been available. Prisoners working on the wing serveries were wearing their own clothes and no head coverings while serving meals. Their training records showed that most had had no training, which was not appropriate.

4.14 Prisoners were regularly consulted about what should be sold in the shop and a good selection of items were stocked suitable for all prisoners and for all cultures and religions. There were, however, restrictions on tinned goods. Prisoners could not access popular items such as mackerel and no alternative had been sourced. Tuna was sold

in pouches as a replacement, but this was too expensive for most prisoners to afford.

Prisoner consultation, applications and redress

4.15 Nearly all applications were completed on prisoner's laptops and despite some poor perceptions from prisoners in our survey, records showed that most applications were responded to quickly.

4.16 In our conversations with prisoners, they were positive about the applications system because it was easy to use the laptops and a permanent record of responses was kept, which they found helpful. Leaders were able to track and address areas that did not respond promptly to applications.

4.17 Most complaints were answered in a timely manner, although a small number had received late responses recently when a key to the complaints box on Swallow wing had been lost. Most of the complaints that we viewed were answered fully and politely and resolved the issues raised. The quality assurance process was effective and any anomalies were addressed quickly.

4.18 An average of 24 complaints a month had been received over the previous 12 months, which was low. Very few complaints could have been dealt with at a lower level.

4.19 An effective monthly prisoner council meeting was facilitated by Kinetic Youth, a not-for-profit youth organisation that helps prisoners to develop life skills. These meetings were well attended and covered a broad range of topics. Several actions were generated which leaders reported directly to prisoner council members at the next meeting. Managers from most departments attended and prisoners could request attendance from staff from a specific area if it was needed.

4.20 A specific topic was discussed each month about an aspect of life in the prison. This was an innovative way to help prisoners develop communication skills and promote open discussion.

4.21 Each wing also had a consultation group which took place sporadically and was not minuted. Prisoners and leaders felt that these groups were not effective and needed revitalising.

4.22 Access to legal representatives had improved. In our survey, 50% of prisoners said that it was easy to communicate with their solicitor or legal representative compared with 28% at our previous inspection and 32% in comparable prisons.

4.23 A large legal visits area was separated into booths that had recently been refurbished. They took place twice a week and records showed that there were enough spaces to meet demand. In our survey, 54% of prisoners said it was easy to attend legal visits compared with 29% in similar prisons.

4.24 When legal mail was opened in error, the prisoner and solicitor were both informed in writing, which was good practice. In our survey, only 42% of prisoners said that staff had opened letters from their solicitor or legal representative when they were not present compared to 61% at similar prisons.

Equality, diversity and faith

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

Strategic management

4.25 The strategic management of equality and diversity remained similar to the previous inspection. Equality meetings were taking place, the collation of data had improved and meetings were well attended. However, data that indicated differences in treatment in areas such as segregation and use of force were not investigated.

4.26 Forums for prisoners with protected characteristics (see Glossary) were held but they were not well coordinated and generated limited actions. Prisoners could not ask to attend or submit their concerns in advance. Information garnered at many of these forums was not shared with the equality meeting for leaders to action and monitor.

4.27 Equality and diversity peer mentors had been re-established since the relaxing of the pandemic restrictions, but many voiced their frustration at not being unlocked enough to deliver support to other prisoners on their wings.

4.28 During the previous 12 months, 20 discrimination incident report forms (DIRFs) had been submitted, 12 by prisoners. The quality of investigations into DIRFs and their responses was mixed. In most cases, relevant individuals were interviewed and there was a good record of the investigation, but responses took too long and did not always resolve the issue. Legitimate issues were not resolved, such as issuing additional pin credit to prisoners from the travelling community (see paragraph 4.30). The deputy governor quality assured all replies before they were returned and the Zahid Mubarek Trust carried out independent analysis.

Protected characteristics

4.29 Prison records indicated that 80% of prisoners identified as coming from a black and minority ethnic background. Some consultation with this group had taken place and celebratory events such as Black History Month had been successfully linked with education. Leaders

had collaborated with motivational community speakers and prisoners said they enjoyed these sessions and valued listening to the talks. The equality manager had worked with the catering manager to reflect multiculturalism in the menu. Prisoners gave examples of Jamaican and Nigerian recipes that had been introduced which they had appreciated. The prison shop carried a good range of multicultural products.

4.30 In our survey, 6% of prisoners identified as Gypsy, Roma or Traveller. Support for these prisoners was very poor. There had been recent consultation with Travellers, but no actions had derived from it. Entitlements such as additional pin credit for those who did not have visitors were inconsistent and only addressed after we raised it during the inspection. Some Travellers complained that adding pin numbers of those with no fixed address was routinely refused. We brought this to the attention of managers who agreed that this was discriminatory and that they would rectify it.

4.31 Foreign national prisoners represented about 18% of the population. Support for them was reasonable. Home office enforcement officers attended the prison twice a week and saw prisoners face to face. They also provided support during induction and attended ACCT reviews where appropriate.

4.32 A professional telephone interpreting service was available for prisoners whose first language was not English. However, leaders preferred to rely on staff and prisoners to translate which was often not appropriate.

4.33 Most of the population was under the age of 21. Leaders had made sure that the gym remained open as much as possible which prisoners appreciated. Maturity training had been delivered to staff working with this age group.

4.34 In our survey 32% of prisoners reported having a disability and work to support this group was underdeveloped. Personal emergency plans were in place for those who would need help evacuating the prison in an emergency, but there was not as much awareness of the support needs of prisoners with less visible disabilities.

4.35 Very few prisoners identified as gay, bisexual or other sexual orientation. Gay prisoners we spoke to said they had received good support from staff and had been given links to local and national LGBT support networks and could talk to staff if they ever felt worried. This was positive.

4.36 There were no transgender prisoners at the time of our inspection. A policy was in place to care for these prisoners with respect and decency.

Faith and religion

4.37 In our survey, 86% of prisoners said their religious beliefs were respected, 94% that they could speak to a chaplain in private and 85% said they could attend religious services if they wished. Chaplaincy provision was good. Facilities included a large chapel, mosque and multi-faith room. In our survey, 41% of prisoners said they were Muslim. The chaplaincy covered most faiths and there were sessional chaplains for the less common faiths. Most wings had helpful signs pointing to Mecca.

4.38 Weekly corporate worship and weekday prayer groups had resumed for all the most common religions, but attendance was low, particularly for Friday prayers, because of the number of keep aparts (see paragraph 3.13). Some prisoners told us they could attend if they wished, but many chose not to, to avoid conflict. The chaplaincy had monitored weekly attendance, but not punctuality. Services rarely started on time and many prisoners, managers and chaplains said that prisoners arrived up to 45 minutes late for corporate worship, which was unacceptable.

4.39 Utensils used to prepare Halal food were managed well in the kitchen and on the wing serveries. Celebratory food for Christmas, Diwali and Eid was served which prisoners appreciated. Planning for celebrations started early which helped to make sure that they ran smoothly.

4.40 Faith groups and the Sycamore Tree programme (a volunteer-led, non-accredited victim awareness programme) had restarted. One Sycamore group had been organised but was no longer taking place following an incident in the chapel. Faith forums were not held consistently, records of meetings were not always kept and limited actions were generated to address prisoners' concerns.

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.

4.41 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

4.42 Central and North West London NHS Foundation Trust (CNWL) delivered primary care, mental health and well-being, substance misuse and pharmacy services. The subcontracted services included Dr PA Secure Health Solutions for GPs and NHS England commissioned an independent provider for dental care.

4.43 The health needs assessment had been produced in 2019 and met the needs of the prevailing population.

4.44 Partnership boards and local governance meetings were held regularly but senior leaders had not addressed the longstanding problems of medicines administration on the units.

4.45 Incident reporting levels were good and potential risks to patient safety were readily identified and addressed.

4.46 There were vacancies in primary care, pharmacy, health and well-being and psychosocial substance misuse teams. Effective cover was provided by regular agency and bank staff and patients had good access to care. Recruitment was in progress, but enhanced checks took too long, and some candidates had withdrawn.

4.47 Staff received regular supervision and appraisal. Mandatory training was up to date, although 50% of staff had not completed intermediate life support training. We raised this with the health care manager who assured us this was being addressed.

4.48 Clinical leaders participated in medicines administration on occasion, but this had not had a detrimental impact on oversight of the wider clinical risks.

4.49 Clinical records met the required standard. The service was inclusive and took account of patients' individual needs and preferences.

4.50 Patients spoke positively about staff. Patient feedback was gathered and used to support service improvement in some areas, but this was not yet fully embedded.

4.51 The health care environment was poor and there were not enough clinical rooms to provide for young adults. One therapy for trauma, eye movement desensitisation and reprogramming had been suspended because of the lack of a suitable confidential space. A recent audit had identified areas of non-compliance with infection control standards and an appropriate action plan had been developed.

4.52 Health care applications and repeat prescription requests were received through the digital prison system and reviewed each day by health care staff (implemented February 2022). Complaints were submitted using a health care or prison complaint form, but we were told that they were not always placed in the health care box and confidentiality could not be assured.

4.53 A health care manager met all complainants face to face to resolve concerns and followed this up with a letter to summarise the meeting. The responses addressed the patient's concern directly, but some were poorly constructed and not written in language which helped the reader's understanding.

4.54 The emergency red bags were heavy and not easily transported, which presented a risk to staff safety. An ambulance was automatically called for an emergency, which was good practice.

Promoting health and well-being

4.55 Despite a health promotion strategy being in place, activity was minimal and ineffective. The health promotion lead was often called to support clinical staff which had a detrimental impact on their ability to develop the service. There were few health information posters and leaflets in health care and some of this information was available in other languages, which was good.

4.56 There were no peer health champions to provide information and support to patients, which was a missed opportunity.

4.57 The service had a policy on managing outbreaks of communicable diseases and followed national guidance on the management of COVID-19, which was good.

4.58 Sexual health clinics were well attended. Patients could access programmes to quit smoking and could purchase vapes, which was appropriate.

4.59 The body mass index of patients who were underweight was monitored. Nutritional supplements were prescribed as required and referrals were appropriately made to a dietitian for additional advice and support. The health care team worked with the gym and kitchen to make sure that patients' diets and medically required exercise encouraged well-being.

Primary care and inpatient services

4.60 GP and nurse clinics were held from Monday to Saturday and there was emergency nurse and/or paramedic cover overnight and at weekends.

4.61 Nursing staff screened new arrivals in a dedicated room on Kingfisher and referred patients to other services as appropriate. A secondary health assessment took place within seven days, which was good.

4.62 Patients were seen promptly for urgent GP or nurse appointments. Patients' applications were processed promptly and there was clinical oversight of triage to make sure that patients were directed to the most appropriate practitioner. There was a low uptake of blood-borne virus and sexual health screening.

4.63 Primary care nurses identified patients due for release and saw each individually to prepare throughcare. This included take-home medication where necessary and a letter for their GP, which was good practice.

4.64 Nurses with specialist interest in asthma and sexual health identified patients and offered regular reviews. There was no specialist nurse for

patients with diabetes, which was a gap. Patients with long term-conditions did not always have a personalised care plan which did not meet practice guidelines.

4.65 A range of visiting practitioners and allied health care professionals included a physiotherapist, podiatrist and optician. Wait times were longer for visiting professionals and there were often delays in bringing patients to appointments which led to a loss of clinical time and delayed patient care.

4.66 Telemedicine appointments with the local hospital did not always work well and the patient had to be rebooked for an external hospital appointment which was an unnecessary duplication of the service. Routine external out-patient appointments were sometimes disrupted by the frequent need for patients to attend A&E following an incident. The administration team monitored cancellations carefully and made sure that patients were rebooked.

Social care

4.67 There was a memorandum of understanding between the prison and the London Borough of Hounslow and partners met regularly to discuss service provision. No patients were receiving a package of social care (see Glossary) at the time of inspection.

4.68 There was an open referrals system, but it was not clear where patients could find information on how to self-refer and staff did not understand what to do if they identified someone who required support. This was a weakness.

4.69 Four referrals had been made during the previous 12 months. Most assessments were carried out in a timely manner although improvement was needed in the communication and recording of actions taken following referral. We identified one prisoner who was due for release within two weeks and, according to records, had not been seen. We received confirmation that he had been assessed, but the record had not been updated, which was unsatisfactory.

4.70 The prison liaised with the local authority when a patient required continuing support on release.

Mental health care

4.71 CNWL delivered mental health and therapy services. The team was well led and worked well with other partners to engage with and address the needs of the patients.

4.72 The service was based on a therapy model and comprised highly skilled and knowledgeable practitioners including clinical psychologist, assistant psychologists, well-being practitioners, a speech and language therapist and drama and art therapist. They worked alongside a smaller, registered mental health nurse-led team and two consultant psychiatrists. Recruitment was in progress for vacancies in the team. Opportunities for supervision and professional development were good.

4.73 The service operated seven days a week. New referrals were discussed at the weekly multi-professional meeting attended by all health stakeholders, where caseloads were allocated. Face-to-face assessments were undertaken within five days and care allocated to a specific case worker based on the identified needs. Caseloads were subject to management review to make sure that patients received safe and effective care, which was good practice.

4.74 Input ranged from guided self-help to regular structured therapeutic support for more common problems and specialist support for individuals with more complex needs. There were waiting lists for therapeutic interventions with waiting times of between eight and 12 weeks. Patients on the waiting list received a consistent face-to-face 'check-in' with a practitioner to provide support, which was good.

4.75 Group work had started and included the initiative 'Boats Not Bars', a partnership between the psychology service, prison gym and Fulham Reach Boat Club to support mental health and well-being through shared experiences. This was a positive initiative.

4.76 Staff attended all ACCT review meetings and assessed patients who had started on an ACCT within 24 hours. Clinical records indicated good support and largely regular contact, although the quality of care planning was more variable.

4.77 There had been no Mental Health Act transfers within the previous 12 months. Release planning arrangements were in place for individuals with identified risk and they received reasonable support.

Substance misuse treatment

4.78 The substance misuse service was delivered by CNWL which provided clinical treatment and psychosocial support and was part of the well-being team. At the time of the inspection, 58 patients were receiving support. Patients we spoke to were complimentary about the care they received and we observed caring interactions between staff and patients.

4.79 The drug strategy had recently been produced and showed good partnership working between the service and the prison. Regular meetings were held to share relevant information and to focus and prioritise service delivery.

4.80 Clinical need and support were minimal and at the time of inspection no patients were in receipt of opiate substitution treatment. The clinical service was managed by a specialist consultant with additional prescribing support from the GPs, which was good.

4.81 The psychosocial team had experienced considerable staffing difficulties during the previous 12 months, which had placed pressure on the whole team to meet the needs of patients. As a result, group work had not restarted and remained a gap in provision.

4.82 All patients were seen on the induction unit within five days and those identified for support were seen in a timely manner for an assessment and a care plan. There was an open referral system and patients could also self-refer, which was good.

4.83 Support took the form of structured, brief interventions or harm reduction work which was noted on the clinical records. There were no separate recovery plans which was an omission.

4.84 A mutual aid service attended the prison each week to provide additional support to patients, which was positive. There were no peer workers which was a missed opportunity to develop the support to patients.

4.85 Release planning was in place and Naloxone treatment and training (to prevent opiate overdose) was offered on the basis of individual needs.

Medicines optimisation and pharmacy services

4.86 Medicines were dispensed remotely by an external department in CNWL and stored, secured and transported safely across the prison.

4.87 Prescribing and administration was recorded on SystmOne (electronic clinical records) and the in-possession risk assessment was accessible.

4.88 In-possession medication risk assessments were in place for most patients but were not consistently adhered to. Many prisoners receiving supervised medicines had risk assessments showing 28 days in possession and no reason had been recorded for the assessment not being followed, which was poor. Patients taking antibiotics did not have them in possession and could not, therefore, take them at prescribed times or receive support to manage their own medication in preparation for release. This was a missed opportunity.

4.89 Supervised administration of medicines took place four times a day in rooms on the unit, but the intervals were not always suitable for the medicines prescribed. ID cards were not issued which presented a risk to patient safety and did not reflect best practice. Some lockable boxes for medicines had been put into shared cells so that patients could secure their own medication, but these had yet to be used.

4.90 We observed medicines administration on one unit where prisoners were being unlocked. This was not safe or confidential and did not adhere to best practice guidelines. Patients on the wings were expected to bring a cup of water with them and, if they did not do so, they had to swallow medication without it. This presented a risk that the medication could dissolve in the patient's throat or oesophagus, potentially causing harm and not achieving the desired therapeutic dose. This undermined patient safety.

4.91 Controlled drugs were administered from a small room on the Wren unit with good supervision by officers which promoted privacy and confidentiality for patients.

4.92 A range of emergency medicines were available for patients to have out of hours. Suitable medicines were available to treat minor ailments and nurses were able to supply and administer vaccinations and salbutamol inhalers.

4.93 Controlled drugs were generally well managed and audited regularly. The prescribing of tradeable medicines was well controlled and only a few patients were on tradeable medicines.

4.94 There were procedures to monitor patient compliance depending on the type of medication. A regular, well-attended medicines management group was attended by pharmacy staff.

Dental services and oral health

4.95 NHS England commissioned an independent dental service for oral health care. The dentist promoted oral health for those who needed it and a dental hygienist had been appointed to deliver additional sessions.

4.96 The health care and dental team triaged patients and offered pain relief as required for those awaiting an appointment.

4.97 Waiting times for appointments were about three weeks. The dental nurse gave advice to patients on how to minimise deterioration in the health of their teeth and gums and this was well documented in patient records.

4.98 Treatment was well documented in care records and there was close monitoring of the quality of x-rays. However, the dentist used their own rather than prison patient software which meant that other health care staff, including in prisons a patient may be transferred to, were unable to access the records. This was poor.

4.99 The dental surgery was functional and all necessary equipment was well maintained. Decontamination procedures were followed and infection control standards were met. The service had enhanced air purification capability, which was positive.

Section 5 Purposeful activity

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

Time out of cell

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

5.1 Although there was enough activity to occupy prisoners, during our roll checks we found 38% of prisoners locked up during the day and only 25% were off the wings working, which was poor for a resettlement prison.

5.2 The daily routine was split into two for most prisoners, half the day in work or education and in the other prisoners were offered exercise, showers, cell cleaning and association.

5.3 The published regime allowed for up to an hour outside for exercise, but in practice this was rarely more than half an hour. The half hour was consistent seven days a week. In our survey, 82% of prisoners said they went outside for exercise more than five days in a typical week compared to 65% at the previous inspection.

5.4 Prisoners on the standard regime of the incentives and earned privileges policy were allocated an hour for association, but only on two weekdays. This was subject to regular curtailments depending on staff levels. Showers were included within this hour and on days that prisoners did not have association they could shower individually or in small groups.

5.5 Some wings were more likely than others to operate a full regime. This was reflected in our survey where only 14% of prisoners, compared to 75% at the previous inspection, said they had association more than five times in a typical week.

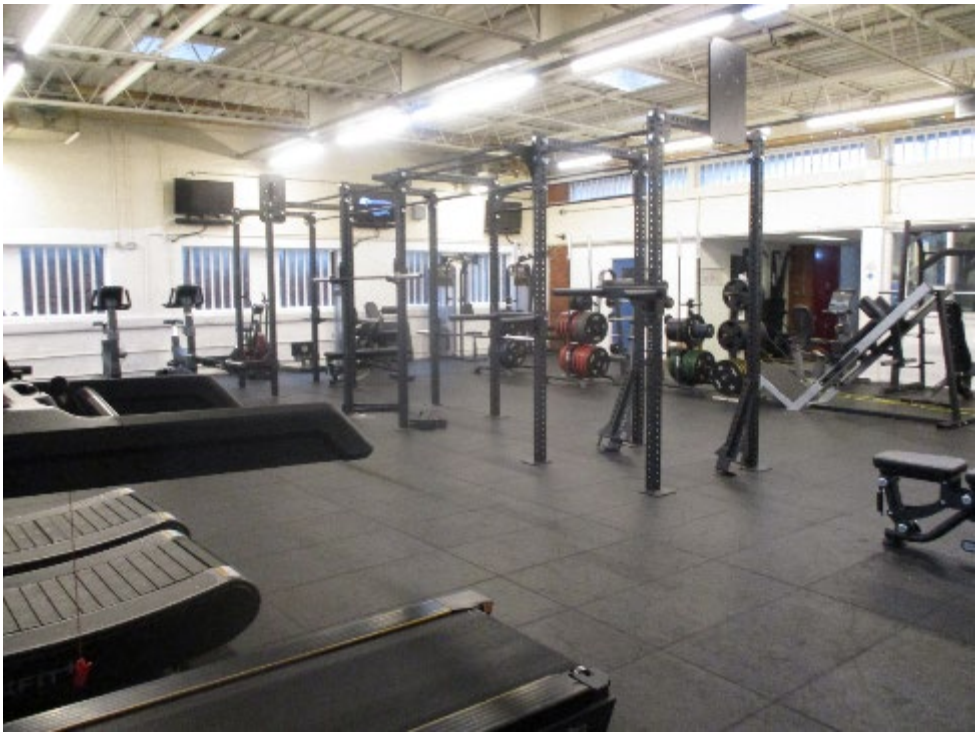
5.6 Prisoners on the enhanced level of incentives and earned privileges policy and those who worked full time were allowed association in the evenings four days a week and this happened fairly regularly. If there were staff shortages, leaders split the available time between two smaller groups so that every prisoner had some access to showers and association.

5.7 Prisoners spent an average of between four and five hours out of cell on weekdays depending on their wing and their specific regime. They had three to four hours out of cell at weekends which was not enough. These averages masked a considerable number of prisoners who received far less than this.

5.8 It took a long time to get prisoners to and from work because of the large number of keep aparts (see paragraph 3.13). Each wing was moved separately and we observed long delays in getting prisoners to work and education.

5.9 Gym provision was good. Prisoners on the standard level of the rewards and sanctions scheme could access two sessions a week and those on enhanced three sessions, a good incentive to promote prosocial behaviour in prisoners of this age group.

5.10 The facilities were good including a football field, rugby field, assault course, weights room and a sports hall with a climbing wall in one corner. The weights room showers had been refurbished to a good standard, but the sports hall showers were in poor condition.



The gym

5.11 Several programmes were running in the gym and, at the time of the inspection, 12 prisoners were taking part in the level two gym instructor course, which was very popular and provided a formal qualification at the end of the course.

5.12 The twinning programme was an eight-week course for 18 prisoners to achieve their level one football coaching qualification and was linked to Brentford Football Club. Saracen's rugby delivered an eight-week life skills course for 20 prisoners and Fulham Reach Boat Club ran a programme to introduce prisoners to rowing.

5.13 Parkrun was popular, where prisoners ran five kilometres around the sports fields each weekend, and some staff came in on their days off to take part.

5.14 The library provided a good service and a considerable number of prisoners used the it each week. The librarians had conducted a needs analysis in summer 2022 and had used this to inform the selection of books that they offered. This had proved very successful and an average of more than 1,000 requests for books or visits to the library were made each month. Prisoners could request a book directly from their laptops which were usually delivered within 72 hours.

5.15 Some good work to promote literacy was carried out. Eighty-seven prisoners had taken part in the reading ahead programme which entailed reading six books and writing a review on each.

5.16 At Christmas 2022 the library had run a quiz on prisoners' laptops in which 173 prisoners had participated with prizes awarded. The quiz included elements of spelling and grammar and informally promoted literacy. Several other quizzes had been organised throughout the year, with good response rates from prisoners.

5.17 The Duke of Edinburgh Award scheme and the Airborne initiative (an outward-bound charity) were offered and a good number of prisoners participated. During the previous 12 months, 98 prisoners had completed some part of the Duke of Edinburgh Award scheme.

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 areas of concern, 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.

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

Overall effectiveness:	Inadequate
Quality of education:	Requires improvement
Behaviour and attitudes:	Inadequate

Personal development: Requires improvement

Leadership and management: Requires improvement

5.19 Novus delivered education and vocational training services in the prison. Managers and teachers had planned the content of the subject areas well and logically. They had designed interesting and mostly challenging learning activities that engaged prisoners well. Prisoners learnt new and useful skills such as in painting and decorating, bicycle maintenance, business and music. Experienced and well qualified teachers and trainers identified learners' starting points. However, they did not always use this information to make sure that all prisoners had access to the support they needed.

5.20 On arrival, prisoners were quickly provided with an introduction to the education, skills and work opportunities that were available. They underwent a thorough assessment of their English and mathematics and any potential learning difficulties and/or disabilities. They also received an initial advice and guidance interview to determine their career aspirations. This information was used to allocate prisoners to the appropriate curriculum pathway.

5.21 Prison leaders had provided well-thought-out curriculum pathways. These were informed by the recently updated curriculum needs analysis in which they took account of the employment opportunities for prisoners based on where they were to be released. This allowed them to study a well-planned series of courses, all of which included English and mathematics, that related to employment or further study once released.

5.22 Prison leaders had provided enough activity places for all prisoners. However, due to concerns related to gang violence, access to education, skills and work opportunities were limited by the extent to which prisoners could mix with each other. This meant that not all the places on courses had been filled and too many prisoners were not allocated. Leaders and managers were working to increase the number of prisoners attending activities but concerns over safety remained a priority and hampered their efforts. This limited the amount of progress they could make to rectify all the deficits identified at the previous inspection.

5.23 Leaders and managers were in the early stages of implementing their reading strategy. Library staff encouraged prisoners to read through initiatives such as reading and literacy competitions. About half the population took part in these activities. Leaders and managers had not yet started offering non-readers support through the Shannon Trust (provides peer-mentored reading plan resources and training to prisons). Prisoners who attended English lessons did not undertake planned learning activities that helped them to improve their reading skills. Consequently, prisoners were not able to improve their reading adequately.

5.24 Prisoners who were allocated to education, skills and work developed practical skills to a high standard. Those on the bicycle maintenance course improved their skills by repairing and up-cycle old bicycles for the Sue Ryder charity. Prisoners enjoyed this work and took great care and pride with what they had achieved. They used the knowledge they had acquired in using basic hand tools and progressed on to the motor vehicle course. In waste management, prisoners learnt how their work contributed to a more sustainable environment and also helped to save the prison money. In painting and decorating, prisoners produced work that was of a good standard. However, in too many areas prisoners did not gain accredited qualifications in recognition of their skills and knowledge. Prison leaders were working closely with managers from the prison education framework provider, Novus, to get these qualifications reinstated. At the time of the inspection, this had not yet been completed.

5.25 Prison instructors did not use the information about what prisoners knew at the start of their education or training to plan personalised training. This meant that, regardless of a prisoner's level of skill or knowledge, they all followed the same training. As a result, more experienced and knowledgeable prisoners were often bored.

5.26 Most tutors in education planned lessons well. They used a range of strategies to help prisoners to develop their knowledge. For example, tutors in barbering used a range of images that helped prisoners understand various skin conditions. In English, tutors split topics usefully into smaller concepts that helped prisoners understand them and apply what they had learnt. Where appropriate, tutors used 'fidget toys' to help prisoners to concentrate. However, in mathematics lessons, tutors' planning was less effective. They did not have high enough expectations of what prisoners in the group could do. They set work that was too easy or repeated topics they already understood. This contributed to prisoners not developing their knowledge and skills sufficiently well. In mathematics, very few prisoners achieved their qualifications and almost none progressed to higher levels of study.

5.27 Tutors helped prisoners to develop their information technology skills through the courses they studied. For example, in business studies, prisoners developed their spreadsheet skills as part of their business planning topic. In English lessons, prisoners used PowerPoint to help develop their presentation skills. The development of these skills helped prisoners to use the laptops they had in their cells.

5.28 Tutors did not always use the information available on a prisoner's additional learning needs. They did not use strategies to support prisoners consistently and a minority of learners did not receive the help they needed.

5.29 Tutors gave feedback to prisoners on their work which helped them to improve. Tutors corrected prisoners' written work which ensured that errors in spelling and grammar were identified and corrected by the prisoners. In music, tutors identified errors and provided detailed

feedback on musical notation. As a result, prisoners knew what they needed to do to improve and how to do it.

5.30 Prisoners' attendance and punctuality in education were poor. Often, half the expected prisoners did not attend lessons because they felt unsafe while in activities. In a few instances, lessons were cancelled due to staff shortages. This resulted in prisoners lacking motivation, although the prison's pay policy did financially incentivise them to attend education.

5.31 The curriculum for English functional skills did not meet the needs of prisoners. There were not enough tutors to provide classes for those prisoners who needed support. Leaders were aware of this shortfall and had recruited staff, but at the time of the inspection were waiting for them to start. This contributed to the proportion of prisoners achieving a qualification in English being too low.

5.32 The proportion of prisoners who achieved qualifications in customer service, business and music technology was high and very high in courses related to prison work, such as food safety, first aid and manual handling.

5.33 Leaders and managers did not have sufficient links with employers to support the high number of prisoners released. This limited how effective staff could be in helping prisoners who were due for release to gain employment. The recently established employment hub had been set up to help rectify this deficit. However, this was still in its infancy and did not yet provide any benefit to prisoners.

5.34 In contrast, prisoners on the Railtrack programme made good progress and secured sustained employment. Prisoners who had completed the theory aspect of the course were given a short work trial with the employer on release.

5.35 Leaders and managers had a good understanding of the quality of education, skills and work and had been working to improve the quality of activities. They also understood the negative impact high levels of violence had on prisoners' access to education, skills and work.

5.36 Most prisoners in education, skills and work understood what constituted a responsible citizen. Prisoners were very polite and respectful to their peers and tutors. They knew that good behaviour would support their application to achieve enhanced status in the prison. Consequently, those prisoners engaged in activities were motivated and readily sought out information that would help them to learn the skills they needed on release.

5.37 Prisoners did not have a good enough understanding of British values. Too many did not remember having had any discussion on the importance of British values. They did not have a secure enough understanding of aspects of respect and tolerance and why they were important. Tutors did not routinely revisit these topics as part of their

teaching and did not reinforce the importance of tolerance for those who might have different views or affiliations.

5.38 Prisoners did not have sufficient support during their sentence to understand the careers available to them on release. As a result, too many did not receive sufficiently comprehensive advice or guidance on selecting education, work and skills during their sentence. Prisoners did not recall receiving careers advice and most did not know how to access it.

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 Support for prisoners to maintain or rebuild family ties was developing. PACT (Prison Advice and Care Trust) had recently been awarded the contract to deliver family support work. They ran the visitors' centre, worked with prison staff to provide family days, and carried out individual casework with prisoners. Future developments were planned, including the Official Prison Visiting scheme (volunteer prison visitors), Storybook Dads (in which prisoners are recorded reading a story to send to their children) and parenting courses, none of which was provided at the time of the inspection.

6.2 Visiting arrangements were reasonable. The visitors' centre was clean with toilets and lockers for visitors' belongings. Drinks and activities for children were offered and advice from the PACT team was available while waiting. Visit sessions of one hour were available on four afternoons including Saturday and Sunday and on Saturday mornings. Visitors we spoke to said they had been treated well by staff.

6.3 In our survey, 43% of prisoners said they had been able to see their family/friends during the previous month. This was better than at similar prisons, but improvement was still needed given the young age of the population. We estimated enough capacity in the visits room for prisoners to have a fortnightly visit, although staff told us that visits sessions were often not fully booked.

6.4 New furniture in the visits room improved the environment, but on the day that we observed visits the area had not been cleaned following the previous day's visits. A cafe area sold hot and cold drinks and food.

Social visits room

6.5 Family days took place monthly for up to 15 prisoners at a time. This gave families the opportunity to interact with fewer restrictions, for example at one visit that we observed prisoners could move around the room to get food and drinks for their visitors and play with their children and PACT workers took family group photos.

6.6 Use of secure video calls (see Glossary) was low. Prison data showed that 5% of video visits capacity had been used during 2022. This was disappointing given that less than half the prisoners said in our survey that they had had more than one visit in the last month.

6.7 The introduction of telephones and laptops in cells enabling prisoners to use the secure 'email a prisoner' service represented improvements to contact arrangements since 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.

6.8 A needs analysis had recently been completed to inform a review of the out-of-date reducing reoffending strategy. Regular reducing reoffending meetings, which were well attended, focused on improving outcomes for prisoners. The recent introduction of the employment/resettlement hub was a good example of an initiative to support prisoners' return to the community (see paragraph 6.28).

Employment/resettlement hub

6.9 The offender management unit (OMU) had benefited from consistent management since the previous inspection but was operating with vacancies in both the prison offender manager (POM) and case administration teams. OMU managers described a two-year freeze in London on the recruitment of probation officers as prison offender managers and the team had little resilience to case manage high-risk prisoners.

6.10 POMs and case administrators were positive about their leaders being approachable and working in supportive teams where advice was readily available. All POMs had regular supervision from the senior probation officer (head of OMU delivery) which supported their development and provided oversight and quality assurance of their work with prisoners.

6.11 Allocation of cases to POMs was timely and appropriate with caseloads of between 50 and 75 cases each. The more complex and high risk were allocated to one of the two probation officer POMs. Band four prison officer POMs were not routinely cross-deployed away from the OMU but could be used to respond to incidents or to work on residential units at weekends.

6.12 Most prisoners met their allocated POM within two weeks of arrival. Subsequent contact between POMs and prisoners varied and tended, appropriately, to be dictated by the needs of the particular case, with priority given to those closest to release and with complex needs. POMs did not routinely record all their interactions with prisoners on electronic case notes, which was an omission. Some prisoners were frustrated by a lack of contact to discuss their sentence progression and release preparation, but key work at Feltham was better than we

often see and helped to mitigate this. Information sharing between POMs and key workers was developing and some examples of useful joint work were seen.

6.13 About a quarter of prisoners had not had an initial assessment of their risks and needs (OASys) and did not have a sentence plan. The POM team worked hard to prevent this backlog increasing but the vacancies in the team made this difficult and was not helped by many community probation teams also having staffing issues. Under the offender management in custody (OMiC, see Glossary) model, responsibility for the management of many cases and the completion of OASys had already passed to the community teams, including 10 of the 12 cases that we reviewed in detail. In these cases, OMU staff had a support role, liaising with their colleagues in the community on the completion of OASys and referral to specialist projects and interventions, including to supported accommodation.

6.14 OMU staff worked to engage with their colleagues in field teams and we saw good examples of joint work by both POMs and community offender managers (COMs). Delays in the allocation of prisoners to COMs, often long after the required handover date, hampered this process. POMs often expended considerable time and energy trying to identify COMs and, in a small team with considerable pressure on its resources, they could have been better deployed.

6.15 In our case sample, while 10 of the 12 had a completed OASys, only four of the OASys had been completed in the last 12 months and were of sufficient quality. In general, the quality of completed assessments varied: sometimes not all sections were completed and a number of the OASys completed by community teams were unsigned and had not apparently been subject to management oversight. Only six of the case sample had a sentence plan, some of which focused on community objectives with little or no reference to custody and were expressed in vague terms unlikely to engage young prisoners. Only two of the 12 prisoners were able to describe their sentence plan objectives and the time in custody for the remaining 10 had had little focus.

6.16 Home detention curfew (HDC) procedures for eligible prisoners were managed efficiently but half of those given HDC over the previous year had been released after their eligibility date, some two or three months later. These cases had been delayed while waiting for community checks to be completed, decisions to be made about further charges for incidents while in custody or places in Bail Accommodation and Support Service or approved premises accommodation.

6.17 At the time of the inspection, no prisoners had indeterminate sentences but there had been an increase in prisoners with extended determinate sentences. A probation officer POM was leading promising work to identify and respond to the specific needs and concerns of these prisoners.

6.18 More attention had been given since the last inspection to identifying prisoners with experience of care. There was evidence of POMs

establishing good working relationships with Leaving Care teams in the community who provided additional support to eligible prisoners both before and after release.

Public protection

6.19 An interdepartmental risk management meeting (IRMM) took place monthly, but the multidisciplinary attendance required in the terms of reference was not consistent. This reduced its effectiveness which was unfortunate as the minutes indicated that discussions focused on key issues and that good efforts were made to hold community teams to account for the timely assessment of prisoners. A public protection steering group was to meet for the first time just after the inspection to keep prison-wide public protection arrangements under regular review.

6.20 All the prisoners in our case sample were assessed as high or medium risk of harm and should have had a risk management plan in their OASys. Only half of the 10 plans that had an OASys were of an acceptable standard. The others, which had been completed by COMs, had missing information and were not of a high enough standard.

6.21 The level of multi-agency public protection arrangements (MAPPA) management was not always confirmed in good time to inform release planning. Only two of seven cases due for release in the next three months had a confirmed MAPPA level and the level of risk of the other five prisoners had still to be assessed by their COM. Actions were identified at the monthly IRMM to support safe release, but too many community teams were slow to respond and arrangements deemed necessary to manage individuals' risk in the community, such as referral to approved premises, were delayed. When POMs were asked to contribute to MAPPA meetings, their contributions were of reasonable quality.

6.22 The OMU team had clear processes for identifying prisoners who required contact restrictions or communications monitoring. Staff who dealt with incoming and outgoing prisoner communications worked from up-to-date lists of prisoners who were subject to restrictions or monitoring. Few prisoners were placed on monitoring, reviews of the necessity for monitoring were undertaken and there was no monitoring backlog. The policy of limiting prisoners subject to monitoring to 25 minutes of phone calls each day was punitive.

Categorisation and transfers

6.23 Completed categorisation decisions were well documented but there were some delays with initial categorisations when prisoners reached the age of 21 and subsequent reviews. Managers were aware that this needed attention. Few individual transfers took place, a source of frustration for several prisoners who raised with us their desire to be closer to home or to be in a prison with more options to progress.

Interventions

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

6.24 Two accredited interventions were offered, the Thinking Skills Programme and Identity Matters which addressed gang issues. This was an addition since the last inspection. Three programmes had run successfully earlier in 2022 but no group work was taking place at the time of the inspection because of vacancies in the programmes team. This meant that some prisoners would be released without completing an intervention that they needed. A small number of prisoners had also completed or were participating in one-to-one programmes. When programmes were completed, there was a good celebration of success and sharing of learning with relevant prison and community agencies.

6.25 Prisoners could take part in non-accredited interventions delivered by 'Belong' (a charity that works with children, young people and adults in custodial and community settings), Kinetic Youth workers (see paragraph 4.19) and the substance misuse and well-being teams. More use was made than we often see of the Choices and Changes toolkit for young adults.

6.26 Many of the population were not eligible for release on temporary licence (ROTL) but a small number of suitable prisoners had been able to use ROTL (nine prisoners for a total of 100 ROTLs between December 2021 and November 2022) to take part in community volunteer work, outward bound-type activities and work experience. It was encouraging that a prisoner had recently secured employment on release following a period on ROTL.

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.

6.27 There was no longer a functioning resettlement team after the final worker had left and had not yet been replaced. This left a gap in provision for low- and medium-risk prisoners whose resettlement plans were not routinely being reviewed 12 weeks before release. A discharge board conducted by a custodial manager helped to identify prisoners' needs but was not shared with the community in the way that resettlement plan reviews had been.

6.28 A new employment/resettlement hub opened during the inspection. Leaders had well developed plans to use it to see all prisoners three months before release to give them the support they needed as they approached their return to the community. Workers who offered support with entitlements and benefits claims, accommodation needs,

CVs and disclosure letters ready for release had been relocated to the hub, which was promising, and potentially gave prisoners easier access to the services. A worker had been recruited to help with opening bank accounts and acquiring identification documents.

6.29 The recent appointment of a prison employment lead reflected the focus on helping prisoners to find employment for their release. The employment lead was part of the New Futures Network (an HMPPS initiative to broker partnerships between prisons and employers). Targeted job fairs were being planned. This initiative was much needed as prison data indicated that few prisoners left Feltham with education, training or employment arranged.

6.30 An average of 20 prisoners were released each month. Prison data showed that nearly all prisoners had accommodation for their release but there was no certainty about its sustainability. On-site support from a St Mungo's accommodation worker was a good resource but depended on the relevant COM commissioning his involvement which could not happen if a COM had not been allocated.

6.31 Release processes were well organised and included checks on licence requirements, return of prisoners' stored property and provision of subsistence payments and travel warrants or payment of fares. Suitable bags and clothes were available if needed. All prisoners being released were strip-searched, which was disproportionate (see paragraph 3.39).

Section 7 Progress on recommendations from the last full inspection report

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.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection in 2019, the reception area provided a welcoming environment. First night and induction processes had improved and were good overall. Fewer prisoners than elsewhere reported experiencing victimisation from other prisoners. Levels of violence against staff had reduced considerably, but against prisoners had risen slightly. Good relationships between staff and prisoners compensated, in part, for weaknesses in behaviour management. Some security procedures were over-restrictive. The prison had drastically reduced the large backlog of adjudications found at the previous inspection. Levels of use of force had risen and governance required improvement. Segregation levels had also risen but stays on the segregation unit were generally short. Levels of self-harm were low. Assessment, care in custody and teamwork (ACCT) procedures were well managed and care for prisoners was reasonably good, although access to Listeners was poor.

Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

Data from indicators of violence should be analysed and understood, to inform an effective plan that reduces the frequency of violence. (S38)
Not achieved

Security arrangements should allow prisoners to access the full and purposeful regime expected in a category C training prison. (S39)
Not achieved

Managers should regularly analyse self-harm data, to understand and address the reasons behind the sharp rise in the number of incidents. (S40)
Not achieved

Recommendations

There should be a published regime for basic prisoners which is adhered to by staff in all residential areas. (1.15)
Achieved

Prisoners in segregation should have access to a shower and telephone call daily. (1.26)
Achieved

Sufficient Listeners should be trained and in place, to give prisoners access at all times. (1.41)
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection in 2019, staff–prisoner relationships were generally good and the keyworker scheme had been implemented well. There was an improved range of opportunities for prisoners to contribute to their community through peer support roles. Communal areas were clean and cells were well equipped, but many contained graffiti. Many of the showers were not fit for use. Complaints were well managed and consultation was improving. The food provided was reasonably good and the prison shop had improved. The management of equality was good but there was limited monitoring of disproportionality. Good health services were undermined by the inability to get prisoners to appointments and serious risks in the administration of medicines. Substance use services were improving.

Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

The conditions on residential units, particularly cells, showers, exercise yards and serveries, should be improved. (S41)
Achieved

There should be regular monitoring of the treatment of prisoners with protected characteristics and their access to the regime, to identify and address discrimination. (S42)
Not achieved

Managers should consult prisoners across all protected characteristics, to ensure that their needs are identified and met. (S43)
Not achieved

Prisoners should have access to health and substance use services at the required times and receive their medicines in a safe manner at the prescribed times. (S44)
Not achieved

Recommendations

Managers should monitor emergency cell call bell response times to ensure they are responded to promptly. (2.9)
Not achieved

Prisoners should be able to dine communally. (2.17, Repeated recommendation 2.82)
Not achieved

Prisoners on the 'keep apart' list should only be excluded from corporate worship following a robust risk assessment. (2.54, Repeated recommendation 2.34)
Not achieved

Patients should be able to complain about health services through a well-advertised, quality-assured, independent health care complaints system. (2.54)
Achieved

The inpatient unit should be used only for clinical purposes, and prisoners should not be located there to address operational issues. (2.66)
No longer relevant

Purposeful activity

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

At the last inspection in 2019, we found 37% of prisoners locked up during the working day. This was far too many for a training prison holding a young population. The library and gym were both good facilities. Leaders and managers had failed to provide enough education, skills and work activities. English and mathematics provision was insufficient to meet demand. There was some good teaching and learning in work and vocational training, but learning in education was undermined by disruptive behaviour. Attendance and punctuality were poor. Achievement rates were high in vocational training. However, too many prisoners did not complete courses and progress was too slow in English and mathematics.

Outcomes for prisoners were poor against this healthy prison test.

Key recommendations

All prisoners should have regular and predictable time out of cell, including sufficient time in the open air to promote rehabilitation and mental well-being. (S45)
Not achieved

Substantial improvements should be made to the quality of education, skills and work provision, so that: all prisoners can be purposefully occupied for the working day; the curriculum and range of activities meet fully the needs and starting points of prisoners; and the regime supports fully purposeful activities, so that attendance and punctuality improve. (S46)
Not achieved

The quality of education, skills and work provision should be improved by ensuring that: learning activities are well planned and provide challenging tasks, so that prisoners make the progress of which they are capable; employed prisoners have enough work to keep them purposefully occupied; and the skills and behaviour that they develop are recorded, so that they can provide prospective employers with an account of the skills they have gained while in custody. (S47)
Not achieved

Steps should be taken to ensure that prisoners' attitudes to learning and work improve, and they are supported and challenged to behave well and develop the personal, social and work-related attitudes and skills that they need to find work on release, reducing the likelihood that they will reoffend. (S48)
Not achieved

The outcomes that prisoners achieve should be improved by: reducing the number who leave education and vocational training courses before they complete them; increasing the opportunities that prisoners have to achieve accredited qualifications through prison work; and recognising and recording the progress and achievements of prisoners who work in activities where accredited qualifications are not available. (S49)
Not achieved

Recommendations

Support and training should be provided to staff, to ensure that they have the skills and confidence to deal with disruptive behaviour. (3.20)
Partially achieved

Tutors and instructors should ensure that individual learning plans record prisoners' prior attainment, clearly identifying targets related to their sentence plans, and regularly reviewing and recording progress against these targets. (3.29)
Partially 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, work to support prisoners to maintain contact with family and friends had improved, but visits facilities were worn and in need of refurbishment. The strategic management of resettlement was reasonably good. Strong leadership within the offender management unit had led to improvements. The backlog in offender assessment system (OASys) assessments had reduced dramatically. However, too many prisoners did not have a current assessment. Contact levels and the quality of casework were reasonably good. Home detention curfew was well managed. Public protection arrangements were better than we normally see and the system for confirming multi-agency public protection arrangements (MAPPA) management levels before release was good. The provision of accredited programmes required improvement. Release planning was reasonably well organised.

Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

All prisoners should have an up-to-date OASys assessment before being transferred to Feltham. (S50)
Not achieved

There should be sufficient provision of offending behaviour courses, based on the prison's needs analysis and population data, to ensure that all eligible prisoners can undertake a suitable programme to address their risks. (S51)
Not achieved

Appendix I About our inspections and reports

HM 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, 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 HM 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 identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for prisoners. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list 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 outlines the priority and key concerns from the inspection and our judgements 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/). Section 7 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 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
Angus Jones	Team leader
Angela Johnson	Inspector
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David Foot	Inspector
Donna Ward	Inspector
Liz Caulderbank	Inspector
Charlotte Betts	Researcher
Helen Downham	Researcher
Rachel Duncan	Researcher
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Steve Lambert	Ofsted inspector
Saher Nijabat	Ofsted inspector
Dave Baber	Ofsted inspector
David Towsey	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/

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.

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.

Offender management in custody (OMiC)
The Offender Management in Custody (OMiC) model, which has been rolled out in all adult prisons, 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).

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

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

Special purpose licence ROTL
Special purpose licence allows prisoners to respond to exceptional, personal circumstances, for example, for medical treatment and other criminal justice needs. Release is usually for a few hours.

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:

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

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