Report on an unannounced inspection of

# HMP Pentonville

by HM Chief Inspector of Prisons

4–5 and 11–14 July 2022

# Contents

# Introduction

HMP Pentonville in north London is one the oldest prisons in the country. It received its first prisoners in 1842 and was designed to hold 520 people in single cells. In recent times, it has routinely been one of most challenging and troubled prisons, with a succession of poor inspections. Our last full inspection in 2019 was no exception to this sorry history, but at our scrutiny visit in 2020 we saw evidence of fragile progress.

At this inspection, the promise of improvements had been realised in part, but many serious concerns remained, including some fundamental weaknesses in offender management and provision of activities. Safety had improved, with much reduced violence, a well-run segregation unit and better governance of force. Nevertheless, there was still a high rate of illicit drug use, there had been seven self-inflicted deaths since 2019 and care for those at risk of self-harm was not yet good enough. In addition, time out of cell and constructive activities were seen, at least in the short-term, as acceptable collateral damage in the drive to improve safety. This approach did not sufficiently recognise that an institution that promotes safety is also one that considers the impact of lengthy periods of lock-up on mental health and on prisoners' chances of being released into society with the skills that might help them to stay out of trouble.

There were other indications of a prison that was headed in the right direction. For example, it was positive to see the ambitious long-term vision represented by the plan for a new unit intended to care for neurodiverse prisoners, and the unusually good work that was done to support young offenders. Leaders had also taken steps to address deep-rooted problems in the staff culture and capability even if results were, so far, limited. However, Pentonville has had more false dawns than most prisons. It is an indication of the profound problems it faces that, despite the improvements that were being made and the considerable dedication and capability of its leaders, outcomes for prisoners were still not good enough in any of our healthy prison tests.

This report gives the reasons for these judgements in some detail, but one concern is worthy of particular mention. Pentonville remains a cramped early Victorian relic, with claustrophobic wings and a crumbling physical infrastructure that require constant repair and refurbishment to meet the most basic standards of decency. The prison currently holds over 1,100 prisoners and this number is continuing to rise. While it has added some new living units, the increased capacity has come about largely by placing two people in cells designed for one. Over 60% of prisoners are in overcrowded cells and the prison's footprint is not markedly different from when it held fewer than half the current number. It is hard to avoid the conclusion that Pentonville cannot safely and decently care for its current population, as illustrated, for example, by the high number of prisoners with mental health needs who could not get prompt appointments, and the wholly inadequate access to purposeful activity. If the prison is to make further progress, national leaders need to accept the limitations of an establishment that has to work harder than most to battle through its entrenched problems.

**Charlie Taylor**
HM Chief Inspector of Prisons
August 2022

# What needs to improve at HMP Pentonville

During this inspection we identified 15 key concerns, of which eight 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. **A high proportion of prisoners said they felt unsafe and in our survey over half said they had experienced some form of victimisation from staff.**

2. **There had been seven self-inflicted deaths since the last full inspection and support for prisoners in crisis was not good enough.**

3. **The prison was severely overcrowded and it could not decently or safely care for the number of prisoners it was currently required to hold.**

4. **The high number of prisoners with low-level mental health needs had long waits for appointments and few prisoners in our survey said they had been helped with their mental health problems.**

5. **Time out of cell was poor for most prisoners.** There were frequent regime curtailments, attendance and punctuality at activities were poor, most prisoners could not visit the library and they had inadequate access to the gym.

6. **Prisoners did not receive sufficient or equitable access to a broad range of education, skills and work based on their needs.**

7. **There were serious deficiencies in the performance of the offender management unit, including work on public protection. There had been some recent progress to address this concern, but it was fragile and depended on temporary staff remaining in post.**

8. **There was little funded resettlement support for almost one half of prisoners who were on remand, affecting their access to release accommodation and other resettlement services.**

## Key concerns

9. **Fewer than half of new arrivals said they felt safe on their first night in custody, and the management of risks was undermined by safety interviews that did not take place with sufficient privacy and the lack of first night checks for most prisoners.**

10. **There was a high level of illicit drug use and staff did not consistently challenge the use of drugs.**

11. **Body-worn cameras were not well enough used and footage from CCTV and body-worn video cameras was not retained beyond a month to inform learning and improve practice.**

12. **Meals continued to be served too early and with lengthy gaps between mealtimes. We saw lunch served from 10.30–11am and the evening meal from 4pm. Breakfast packs were handed out at lunchtime the day before they were to be eaten.**

13. **There was insufficient support for prisoners from protected groups, including the large population of foreign nationals.**

14. **The primary care health service had a high nursing vacancy rate and not all agency staff had access to keys, which limited the duties they were able to carry out independently.**

15. **There was too much variation in the quality of teaching across education, skills and work.**

**Care Quality Commission regulatory recommendation**

Providers must have a suitable system in place to ensure patients receive safe care and treatment and that avoidable harm or risk of harm is prevented.

# About HMP Pentonville

**Task of the prison/establishment**
Local category B resettlement prison for remand and convicted male prisoners aged 18 and over.

**Certified normal accommodation and operational capacity (see Glossary)**
Prisoners held at the time of inspection: 1,111
Baseline certified normal capacity: 928
In-use certified normal capacity: 871
Operational capacity: 1,115

**Population of the prison**
- 4,232 new prisoners received each year (around 353 per month).
- 312 foreign national prisoners.
- 70% of prisoners from black and minority ethnic backgrounds.
- 387 prisoners receiving support for substance misuse.
- 205 prisoners referred for mental health assessment or support each month.

**Prison status (public or private) and key providers**
Public

Physical health provider: Practice Plus Group
Mental health provider: Practice Plus Group, Barnet, Enfield and Haringey Mental Health NHS Trust
Substance misuse treatment provider: Phoenix Futures
Prison education framework provider: Novus
Escort contractor: Serco

**Prison group/Department**
Public Sector Prisons South – London

**Brief history**
HMP Pentonville is a large Victorian local prison with four wings, unchanged since it was built in 1842. It is one of the busiest prisons in the country.

**Short description of residential units**
A wing – 210 spaces, general remand and convicted prisoners, first night centre.
C wing – 150 spaces, general remand and convicted prisoners.
D wing – 160 spaces, general remand and convicted prisoners.
E1 wing – segregation unit, 12 spaces.
E2-5 wings – 130 spaces, general remand and convicted prisoners.
F1-3 wings – 116 spaces for prisoners requiring substance misuse stabilisation.
F4-5 wings – 54 spaces for vulnerable prisoners.
G wing – 400 spaces, general remand and convicted prisoners (G1 currently decanted).
J wing – 60 spaces, drug-free wing.
Health care – 22 beds.

**Name of governor and date in post**
Ian Blakeman, December 2019

**Changes of governor since the last inspection**
Darren Hughes, August 2018 – December 2019

**Prison Group Director**
Ian Bickers

**Independent Monitoring Board chair**
Alice Gotto

**Date of last inspection**
1–2 April 2019

# Section 1 Summary of key findings

1.1 We last inspected Pentonville in 2019 and made 39 recommendations, 16 of which were about areas of key concern. The prison fully accepted 26 of the recommendations and partially (or subject to resources) accepted 11. It rejected two of the recommendations.

1.2 In November 2020, during the COVID-19 pandemic, we conducted a scrutiny visit at the prison. We made eight recommendations about areas of key concern.

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

## Progress on key concerns and recommendations from the full inspection

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

1.5 At our last full inspection, we made 16 recommendations about key concerns. At this inspection we found that three of those recommendations had been achieved, one had been partially achieved and 12 had not been achieved. Three recommendations in the area of safety had been achieved, one had been partially achieved and three had not been achieved. None of the four recommendations on respect, two recommendations on purposeful activity and three recommendations on rehabilitation and release planning had been achieved. For a full summary of the recommendations achieved, partially achieved and not achieved, please see Section 8.

## Progress on recommendations from the scrutiny visit

1.6 During the pandemic we made a scrutiny visit to HMP Pentonville. Scrutiny visits (SVs) focused on individual establishments and how they were recovering from the challenges of the COVID-19 pandemic. They were shorter than full inspections and looked at key areas based on our existing human rights-based *Expectations*. For more information on SVs, visit https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/scrutiny-visits/.

1.7 At the SV we made some recommendations about areas of key concern. As part of this inspection we have followed up those recommendations to help assess the continued necessity and proportionality of measures taken in response to COVID-19 and how

well the prison is returning to a constructive rehabilitative regime, and to provide transparency about the prison's recovery from COVID-19.

1.8 We made eight recommendations about areas of key concern. At this inspection we found that one of the recommendations had been achieved and seven had not been achieved.

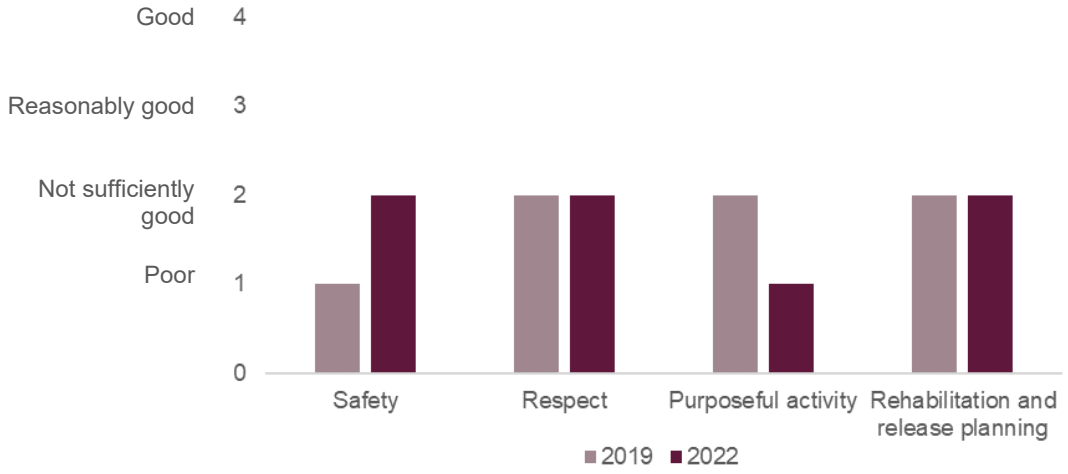
## Outcomes for prisoners

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

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

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

**Figure 1: HMP Pentonville healthy prison outcomes 2019 and 2022**




### Safety

At the last inspection of Pentonville in 2019 we found that outcomes for prisoners were poor against this healthy prison test.

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

1.12 New arrivals had a thorough initial safety interview in reception, but it was undermined by a lack of privacy. A high number of prisoners felt unsafe on their first night and most did not have any first night checks. Induction was adequate but new arrivals spent around 23 hours a day

locked up, often for more than seven days because of a lack of space on other units.

1.13 In our survey, 40% of prisoners said they currently felt unsafe, which was worse than at similar prisons (23%). Over half of prisoners in our survey said that they had been victimised by staff in some way, and a high proportion of staff reported seeing their colleagues behaving inappropriately towards prisoners.

1.14 The level of violence had reduced, to some extent because of the strict cohorting (see Glossary) of prisoners. There was useful work to support young adults with problematic behaviours. Oversight of violence reduction had recently improved. Prisoner peer workers were not used to help mediate and prevent violence, which was a missed opportunity.

1.15 Use of force had reduced since the last full inspection and managerial oversight was now reasonable. Footage of use of force showed some good practice, but also several instances of disproportionate and heavy-handed behaviour with a lack of de-escalation. Staff did not use body-worn cameras sufficiently well, undermining accountability.

1.16 The segregation unit had improved. It was used for short periods and staff were calm and professional, forming good relationships with prisoners there. The creation of a time-out room to help relax and support prisoners with challenging behaviours was a good initiative.

1.17 The supply of illicit items, including drugs and mobile phones, remained a major threat to the prison. A drug strategy and action plan were now in place and there had been other initiatives to manage and reduce drug use. However, the volume of drugs in circulation was still high and prisoners were clearly smoking illicit substances on the wings without consistent challenge by staff. Physical security had improved, but gate security remained particularly weak.

1.18 There had been seven self-inflicted deaths since the last full inspection. Action plans to address Prisons and Probation Ombudsman recommendations were not consistently reviewed or sufficiently embedded. The recorded level of self-harm was broadly similar to the last full inspection. Support for prisoners in crisis was not good enough. Assessment, care in custody and teamwork (ACCT) case management was weak and residential officers were not sufficiently involved in prisoner care; some were not even aware of those on ACCTs. Adult safeguarding arrangements were good.

**Respect**

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

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

1.19 Although we saw some evidence of good staff-prisoner relationships, we saw many examples of rude and dismissive behaviour by staff and a high proportion of prisoners reported verbal abuse from them. The introduction of short training sessions to support staff in working with prisoners was a positive initiative. Very little key work was taking place.

1.20 Communal areas were cleaner than at the last inspection, but living conditions remained cramped and many cells were overcrowded. The ventilation was poor, especially in cells with vented windows that could not be opened, and some were extremely hot during the inspection. There were insufficient showers and many prisoners could not shower every day. Staff responses to cell bells continued to be slow.

1.21 Lunch and evening meals continued to be served very early and food remained a prominent source of prisoner complaint. There were major problems with the prison shop provision, which the prison was addressing.

1.22 Responses to prisoner complaints often lacked detail and some in our sample had not received any reply at all. Quality assurance had only recently resumed. Wing Insiders helped prisoners to make applications, but the quality of the work differed between the wings and there was inconsistent oversight of their work. Consultation with prisoners had only restarted the week before the inspection.

1.23 Equality and diversity work had received little priority. There was some good collection and analysis of data, but this was yet to drive change. The Time4Change course (see paragraph 4.25) was an impressive intervention to help young people, but apart from this there was little support for prisoners from protected groups, including the large population of foreign nationals. There had been some progress in helping prisoners with mobility problems to move around the prison, but the physical layout remained unsuitable for them.

1.24 The chaplaincy was highly valued by prisoners and played a full part in the life of the prison, with the help of a large volunteer group.

1.25 Governance and oversight of health care were generally effective. Prisoners were very frustrated at the lack of response to health care applications and we found evidence to support their concerns. The inpatient unit provided a therapeutic regime and effective health oversight. There was a high number of prisoners with low-level mental health needs who could wait too long for appointments. Prisoners with acute health needs were well supported.

**Purposeful activity**

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

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

1.26 Our roll checks and local data suggested that only around one quarter of prisoners were engaged in purposeful activity during the core day. A high number of prisoners were locked in their cell for over 22 hours a day and the weekend regime was even worse. There were frequent slippages in unlock times and regime curtailments were common, causing much prisoner frustration. Only one wing had regular access to the well-stocked library. Prisoners had insufficient access to the gym.

1.27 While there were sufficient part-time activity places, the prison's policy of limiting activities to particular wings had severely curtailed opportunities for education, skills and work activities. The minority who reached activities developed good skills, but there was little accreditation. Allocation to work on the wings was inequitable and based on prison staff discretion rather than prisoner need.

1.28 Prisoners' attendance and punctuality in education, skills and work were poor. The prisoner pay policy was not an incentive to attend education, which was paid at a lower rate than work. While the education provider used a range of quality improvement approaches, these did not extend to prison work.

1.29 Staff collected information on potential learning support needs during the education induction but little use was made of this information. A minority of prisoners had access to meaningful enrichment activities.

**Rehabilitation and release planning**

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

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

1.30 Visits provision had much improved since the last inspection, although the children's area remained unsuitable. Visits only lasted an hour but generally started on time. The prison was about to resume family days, and social video calls were still available and widely used. PACT (Prison Advice and Care Trust) provided good support to prisoners and their families in the visitors' centre and through its family engagement worker, and had just appointed a family relationship tutor, which was positive. Prisoners now had in-cell telephones, which had greatly improved family contact.

1.31 The reducing reoffending strategy was weak and it had taken too long for the prison to identify major deficiencies in the performance of the offender management unit. Two managers had recently been seconded to the prison to address these problems. Some promising data suggested improvements in the performance of the team, and there were now basic processes to address the identified concerns. However, improvements were fragile and threatened by temporary contracts and staff shortages.

1.32 There had been very long delays in the assessment of prisoners for home detention curfew. Most eligible prisoners had been transferred or released before their case could be assessed. Previous long delays in the categorisation of new prisoners were reducing and a high number of progressive transfers now took place.

1.33 Around a half of prisoners were assessed as presenting a high or very high risk of serious harm. Processes for managing them were poor, although slowly improving. Mail and telephone monitoring arrangements were generally well managed.

1.34 Key resettlement interventions, such as the provision of accommodation, were now only available for sentenced prisoners, leaving the very high proportion of remand prisoners with limited services. Many prisoners were released without accommodation or a job. Accommodation support was good for the minority of prisoners released on licence, and the Jobcentre Plus team provided effective support for remand as well as sentenced prisoners. The pre-release team had chronic staff shortages and was unable to review all pre-release resettlement plans. Good through-the-gate mentoring support was available to a small number of prisoners, but the prison was no longer running a pre-release 'departure lounge'.

## Notable positive practice

1.35 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.

1.36 Inspectors found five examples of notable positive practice during this inspection.

1.37 One cell in the segregation unit had been renovated into an impressive and innovative time out/meeting room with soft furnishings and motivational displays on brightly coloured walls. It was a good initiative to incentivise prisoners and also provided support for the few who were segregated for longer periods. (See paragraph 3.34.)

1.38 Segregation staff received a useful weekly group reflective practice meeting with an onsite psychologist, which gave them a chance to discuss the difficulties they may have encountered on the unit. (See paragraph 3.33.)

1.39 Prison leaders had recognised the need for more training to support staff in their roles, and short training sessions had been set up to deliver a variety of topics to help build staff confidence in their day-to-day work. (See paragraph 4.3.)

1.40 The prison continued to resource the valuable Time4Change course, a bespoke and effective 12-week course delivered to around 35 under-

25s a week. Facilitators had a good understanding of this population and made good use of peer mentoring outside of sessions. (See paragraph 4.25.)

1.41 The well-being unit supported vulnerable prisoners with a structured therapeutic regime and enabled positive outcomes for those with both primary and secondary mental health needs. (See paragraph 4.59.)

# 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 The governor and deputy governor provided energetic senior leadership that had helped to drive improvement in the prison, but progress was fragile and many outcomes for prisoners remained insufficient. Prison leaders had taken robust action to strengthen the senior and middle management teams, and the more collaborative team culture that we noted at our scrutiny visit in November 2020 was being sustained. However, our survey and discussions with staff indicated that the leadership team had yet to gain their full confidence, with many reporting low morale in our survey. There was a perception that leaders had not yet succeeded in developing a sufficiently accountable and professional culture.

2.3 However, prison leaders had taken the task of improving staff culture seriously and were addressing staff capability through regular 'speed training' events (see paragraph 4.3). The prison group director's office was actively supporting these efforts; the director had provided additional resources and had commissioned an occupational psychologist to assess how concerns about prison culture could be measured and addressed across London prisons.

2.4 A strong leadership focus on safety had led to major improvements, especially in the governance of segregation and use of force, but there were ongoing weaknesses in the management of self-harm. While the drive to improve safety had reduced violence, leaders' plans to make sure that prisoners had adequate access to activities while maintaining the separation of wings did not look achievable. There had been a generally inadequate leadership focus on improving access to activities.

2.5 Poor leadership of the offender management unit over a long period had created major risks. This had been addressed by recruiting capable new leaders, and outcome data indicated that progress was being made. However, the extra staffing currently committed to this area was due to end after October 2022. It was clear that sustained progress could not be achieved in such a short timescale and required ongoing investment of time and staff resource.

2.6 Prison leaders had tried to mitigate the crumbling prison infrastructure through refurbishment and redesignation of some landings. However, the prison was overcrowded and national recognition was needed of

the fact that it could not decently or safely care for the number of prisoners it was currently required to hold.

2.7 With some notable exceptions, such as the Time4Change programme aimed at young prisoners (see paragraph 4.25), a theme of the inspection was the lack of recorded information and adequate data. This was improving, but not at a fast enough rate. The prison's self-assessment report was realistic, but the priorities were too broad, which could undermine focused progress.

# Section 3 Safety

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

## Early days in custody

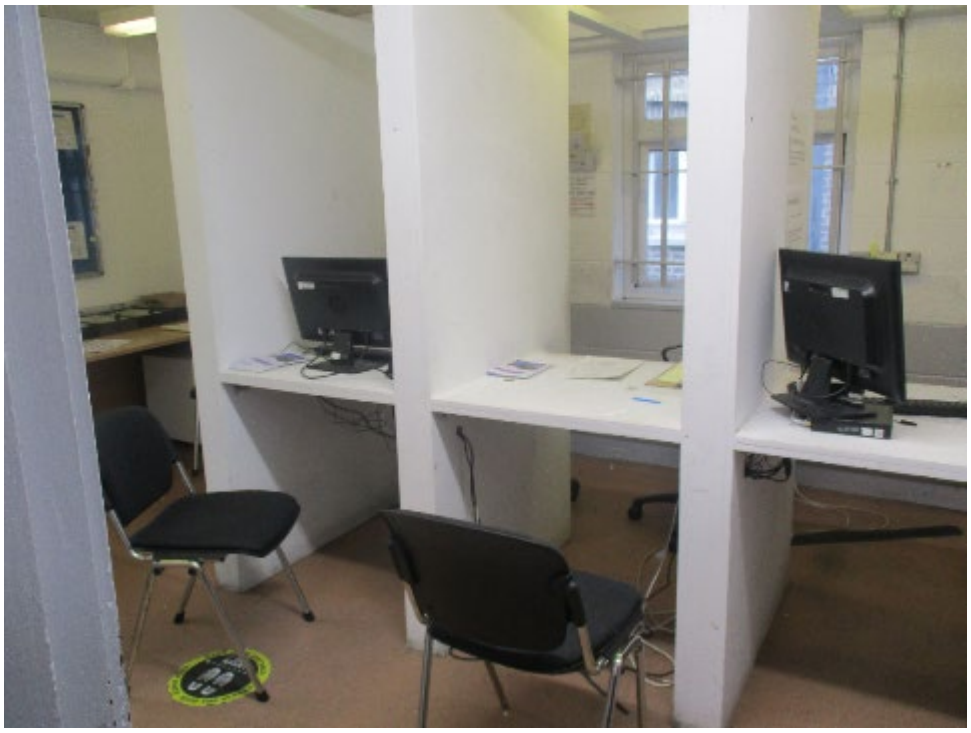
Expected outcomes: Prisoners transferring to and from the prison are safe and treated decently. On arrival prisoners are safe and treated with respect. Risks are identified and addressed at reception. Prisoners are supported on their first night. Induction is comprehensive.

3.1 Pentonville had received over 4,000 new arrivals in the previous year. The physical environment of the reception area was in need of refurbishment and decoration; holding rooms were bleak and several areas were messy. Prisoners could spend over four hours, and often much longer, waiting in reception. We saw some reception staff being impatient and unwelcoming, and in our survey only 65% of prisoners said they were treated well in reception compared with 77% at similar prisons.

**Reception holding room**

3.2 New arrivals underwent a thorough search process before receiving an initial safety interview that explored potential vulnerabilities. Prisoners were also given a declaration form relating to gang or area tensions (see also paragraph 3.41) and an equality questionnaire. However, multiple interviews took place simultaneously in the same area, with limited separation, and with staff and prisoners walking in and out of

the room. This environment was unlikely to encourage prisoners to reveal sensitive information.



**Reception interview room**

3.3 Most prisoners we spoke to said they were not offered a shower on arrival, and some of the showers in reception were being used for storage. There were some reception orderlies, including Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners).

3.4 All new arrivals were located on the induction wing for at least seven days to complete their induction. Cells on this unit were austere, shabby and many had graffiti. Only 45% of prisoners in our survey said they felt safe on their first night at Pentonville, against the 66% comparator, and there were usually no additional checks on prisoners during their first night in the prison.

**First night cell**

3.5 Leaders had just changed the regime on the induction wing to give prisoners one hour a day out of cell; previously, the regime had offered little more than a shower and time out in the fresh air. However, as with the rest of the prison, this offer was limited by frequent curtailments and many prisoners reported going for days without showers (see paragraph 4.5).

3.6 The induction was delivered by a prison officer in a relatable way and covered the basic aspects of daily life, although some information was out of date. Multidisciplinary input was limited and consisted of the chaplaincy visiting all new arrivals and most prisoners receiving an education induction.

3.7 Due to pressures in the population flow, prisoners often stayed on the wing beyond their induction and were therefore subjected to the limited regime for a prolonged period. Staff were also assisting an additional cohort of vulnerable new prisoners (see paragraph 3.16), which placed further pressure on their time and made it difficult for them to increase time out of cell.

## 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

3.8 The level of violence had reduced by about 27% in the previous 12 months compared with the previous full inspection and was broadly in line with similar prisons. The rate of assaults on staff had increased from 128 per 1,000 prisoners to 155 but had been on a downward trend in the past 12 months. The level of violence between prisoners had decreased by 30% (427 per 1,000 to 299) and was similar to other comparable prisons.

3.9 Some of the reduction in violence was attributable to the cohorting of prisoners (see Glossary). While this was having some impact, it could not be a long-term solution as it was hard to sustain while also delivering adequate activities (see paragraph 5.11).

3.10 Despite the reduction in violence, in our survey, 40% of prisoners said they felt unsafe at the time of our visit, compared with 23% for similar prisons. To some extent, this appeared to be linked to staff behaviour: in our prisoner survey, 53% reported some form of victimisation by staff, and in our staff survey, a high proportion of staff also said that they had witnessed their colleagues behaving inappropriately towards prisoners (see paragraph 4.1).

3.11 The management of violence reduction work had improved since the last inspection but the safer custody team was under-resourced as a result of cross-deployment and vacancies. Violent incidents were now investigated but records were incomplete, and it was unclear what level of investigation was undertaken or if lessons were being learned.

3.12 Challenge, support and intervention plans (CSIPs) had been introduced to manage perpetrators of violence and 12 prisoners were subject to one at the time of our inspection. They were sometimes also used to support victims. The quality was mixed and several had no meaningful interventions and infrequent reviews. Wing staff we spoke to did not know which prisoners were on a CSIP and did not understand the benefit of such support or the link to reducing further violent incidents.

3.13 Leaders attributed much of the violence to the high number of prisoners with gang affiliations, which was the trigger for many violent incidents. Some incidents were also linked to the supply of drugs and associated debt (see paragraph 3.41). Despite this, there were not enough formal interventions for these triggers.

3.14 There was some very good support for young adults, who were over-represented in the number of violent incidents. They were targeted with the impressive 12-week Time4Change course (see paragraph 4.25). This was delivered to three different groups each week and was reaching some prisoners with the most concerning behaviours. There was evidence of a positive impact on behaviour during the course.

3.15 Further support was offered to both adults and young adults by Pentonville's enhanced support service (ESS). This consisted of a forensic psychologist, mental health nurse and a dedicated officer.

Prisoners involved in violence, self-harm or those who struggled to settle into the prison regime were offered weekly sessions with two ESS workers each. This was a good level of support but it only reached a small number of prisoners and, at the time of our visit, only six prisoners were on the ESS caseload.

3.16 There was little formal support for victims of violence. There were dedicated landings for vulnerable prisoners and newly arrived prisoners, but other than moving a prisoner at risk, limited support was provided.

3.17 Oversight of violence had improved with a monthly strategic meeting that had restarted in the previous month. There were weekly briefings on safety and a weekly safety intervention meeting, but the minutes did not show any strategic discussion to inform practice with associated action planning.

3.18 Pentonville offered too few incentives to promote good behaviour or foster a rehabilitative culture. The formal incentives scheme remained largely ineffective, with little distinction between the standard and enhanced levels. In our survey, only 29% of prisoners said the incentives scheme helped them to behave well, compared with 40% in similar prisons. The few prisoners on the basic level of the scheme did not receive support to change their behaviour.

3.19 The substance-free living unit (J wing) provided a better opportunity for incentivising behaviour. Prisoners lived in smaller units with better living conditions, including access to cooking and washing facilities (see paragraphs 4.6 and 4.11). A range of activities, such as yoga and keep fit, were provided, often led by prisoners. All prisoners on J wing had a job and there was a good ethos of mutual support, which had led to some support groups being run.

3.20 Violence reduction peer workers were not used to mediate, prevent violence or work with perpetrators and victims, which was a missed opportunity.

## Adjudications

3.21 In the past 12 months, 2,548 adjudication charges were heard. Our review of adjudication records showed that hearings were prompt and adjudicating governors usually explored the underlying issues leading to a charge.

3.22 A high number of charges (just under 30%) were dismissed or not proceeded with. While in some cases this was justifiable, for example due to a lack of evidence, too many were due to procedural errors.

3.23 A range of data were gathered and presented at the quarterly adjudications standardisation meeting, including monitoring for disproportionate outcomes, but it was unclear how this information was used to inform improvement. This forum did not scrutinise individual adjudication records.

## Use of force

3.24 There had been 629 recorded incidents of use of force in the previous 12 months, which was fewer than at the previous inspection. Most incidents (70%) led to full restraint, suggesting that staff could make better use of de-escalation techniques and low-level guiding holds to safeguard the safety of staff and prisoners. Nearly all incidents (97%) were spontaneous and unplanned.

3.25 We reviewed a sample of footage of use of force. Much footage was not available because staff did not routinely operate body-worn video cameras during incidents (they were used in approximately half of incidents) and Pentonville did not retain any CCTV footage over a month old. This meant there was little evidence from incidents to inform learning.

3.26 The footage we viewed showed mixed practice. While some officers were effective in diffusing highly volatile situations in a caring and efficient manner, we also saw several instances of disproportionate and heavy-handed behaviour and a lack of de-escalation. We were not therefore assured that all force used was proportionate, necessary and justified.

3.27 Staff statements relating to force were largely up to date and completed promptly. A fortnightly scrutiny meeting reviewed a sample of between six and eight incidents and had identified and addressed disproportionate uses of force, although the minutes were often not clear about the actions taken. A monthly strategic meeting examining trends and patterns emerging from the prison's use of force data had only commenced in the previous month.

3.28 It was positive that special accommodation had only been used on two occasions in the past 12 months. However, the relevant paperwork was of poor quality; in one case, written observations indicated that the prisoner had calmed down but was not removed at the earliest opportunity.

## Segregation

3.29 The segregation unit was quiet, staff were calm and professional, and relationships with prisoners were good. Staff we spoke to knew the prisoners in their care well. As at the previous inspection, communal areas were reasonably clean, but cell toilets and sinks were dirty with no lids and the shower cubicle was in a poor state of repair. The exercise yard was a good size, with a large multi-purpose fixed exercise equipment and some seating.

**Care and separation unit shower and toilet**

3.30 There had been 537 uses of segregation in the previous 12 months. Staff tried to reintegrate segregated prisoners back into the general population as quickly as possible and prisoners spent relatively short periods in the unit - an average of five days in the past 12 months. While they were on the unit, the daily regime for prisoners was inadequate, with time out of cell restricted to 30 minutes' exercise, a phone call and a shower. A range of library books were available and replenished weekly.

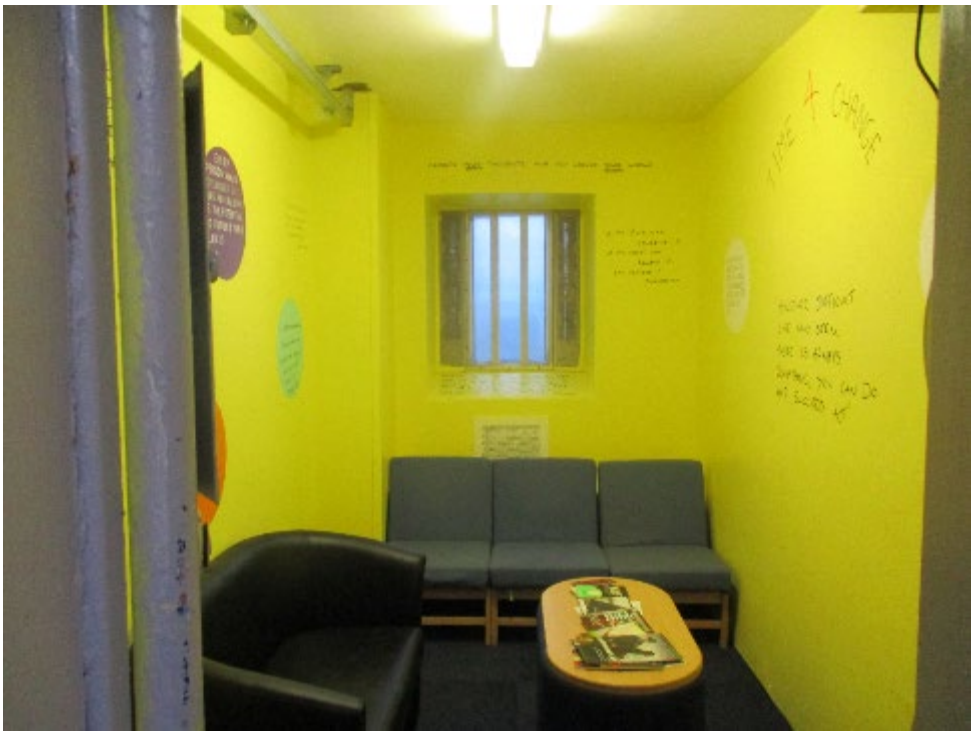
3.31 Strip-searching was routine for all prisoners who were moved to the segregation unit, with no individual risk assessment to determine its necessity. Unlocking arrangements on the unit were proportionate. We were told that appropriately risk-assessed prisoners could exercise together.

3.32 Formal segregation reviews were held regularly but segregation paperwork and review files were often incomplete and did not reflect the good care that we saw. The documented reasons for segregation were generally adequate, but little attention was paid to reintegration planning and objectives were not tailored to the prisoner.

3.33 Unit staff received a useful weekly group reflective practice meeting with an onsite psychologist. This confidential group meeting allowed

staff to discuss the difficulties they may have encountered in their work on the unit.

3.34 One cell in the segregation unit had been renovated to provide an innovative time-out/meeting room. All fixed furniture had been removed and replaced with soft furnishings, and motivational signs were displayed on brightly coloured walls. We saw prisoners who were located in this room to speak with visitors through a gated cell door. This was a good initiative to incentivise prisoners, and also provided support for the few segregated for longer periods.



**CSU timeout room**

## 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 The supply of illicit items, including drugs and mobile phones, remained a major threat to safety and security. A drug strategy and action plan in place since September 2020 had resulted in some positive initiatives to address demand and supply. For example, the introduction of an incentivised substance-free living unit (see paragraphs 3.19 and 4.68) had had a positive impact on supporting both demand and supply reduction initiatives. Nevertheless, the reintroduction of random drug testing in April 2022 following the removal of COVID-19 restrictions had yielded a positive test rate of 38%, among the highest of all adult male prisons. During our visit, there was also a smell of illicit substances in

residential areas, but little evidence that staff consistently challenged prisoners.

3.36 Leaders had focused their attention on the main security risks, including the supply of drugs and illicit items, organised crime and staff corruption. Investment had improved physical security, including upgraded CCTV, the introduction of a body scanner and anti-drone netting. Evidence from local data showed that these improvements had had a positive impact on blocking supply routes that had been used for trafficking. Nevertheless, gate security was weak and the current gate design did not allow for much-needed enhanced searching, although new facilities were under construction.

3.37 Innovative methods to tackle staff corruption included targeted searching with external police support. However, in our staff survey more than half of staff who said that they had raised whistleblowing concerns said that they were not taken seriously, and a third of all staff who responded said they would not raise concerns or were not sure if they would.

3.38 Newer inexperienced staff also presented additional challenges for basic security procedures. For example, during our roll checks, staff were not always confident about the location of prisoners in their care or the exact number on the unit at that time. This was concerning given that several prisoners were considered to be an escape risk.

3.39 All security related reports were now collated and analysed promptly and at the time of our visit there was no backlog. This enabled the prison to produce a detailed monthly tactical assessment to identify gaps in intelligence and provide other departments with an appropriate understanding of current risk.

3.40 In the previous six months, there had been over 250 finds of illicit items, mostly drugs, mobile phones and weapons. However, staff shortages meant that not all intelligence was acted on immediately. During the same period, there had been 389 identified cell searches but only 330 completed, resulting in 149 finds. Similarly, despite good intelligence to drive suspicion-led testing, only 11% of requested tests for April and May 2022 had been completed as resources had been used to carry out the HMPPS target-driven mandatory testing programme.

3.41 Serious and organised crime gangs were a threat to the prison and there were over 100 known nominals in the prison at the time of the inspection. Several of these prisoners were involved in the supply of drugs, phones and weapons, which affected prison safety and associated prisoner debt. Leaders worked closely with the police and other external agencies to address these concerns and the associated gang-related violence, but there were no longer formal interventions to address gang-related violence (see paragraph 3.13).

## 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 seven self-inflicted deaths since the last full inspection, although none in the previous year. The prison had several action plans to address the recommendations following investigations into deaths in custody by the Prisons and Probation Ombudsman (PPO). These plans had previously been discussed at the monthly safer custody meeting, but there had been no consistent review of PPO actions in the last six months, and it was not clear which recommendations in the various action plans were fully completed or sufficiently embedded. Similarly, investigations into attempted suicide incidents did not always evidence detailed investigation or follow up.

3.43 HMPPS data showed that around 30% of all new arrivals had a history of self-harm. Levels of reported self-harm were broadly similar to the last full inspection in 2019, but recent data evidenced that the rate of self-harm was reducing over the previous 12 months. There had been 542 reported incidents involving 163 prisoners, of which 23 required hospital treatment.

3.44 There had been 590 assessment, care in custody and teamwork (ACCT) case management documents opened in the previous 12 months, with 36 open during the inspection. Support for prisoners in crisis and those on ACCT was not good enough; in our survey just one in four who had been on an ACCT said that they felt cared for, and this was reflected in our conversations with prisoners. While some told us of valued support by some staff, they also gave examples of dismissive and even goading comments from staff.

3.45 ACCT case reviews were conducted by senior officers and those we examined were sufficiently detailed, but associated care plans were often incomplete or not used effectively to deliver tailored care and relevant support. Residential officers who often had the most contact with prisoners on ACCT were not sufficiently involved in their care and some were not aware of which prisoners in their areas of responsibility were on an ACCT. This was reflected in the poor completion of records, which too often lacked sufficient detail. Senior leaders were aware of these concerns and had advanced plans to improve case management, which included ongoing training and the use of named case managers.

3.46 There was insufficient leadership and oversight of suicide and self-harm prevention work. There had been just one formal safety meeting

in 2022, which meant that action planning and oversight for continuous improvement, including review of PPO plans (see paragraph 3.42), were lacking. This was somewhat offset by a weekly safety intervention meeting and a data meeting that discussed current safety data, including hotspots, although the minutes did not record identified risks and subsequent actions. A new senior lead for safety had reviewed the current position and an experienced member of staff had been appointed to provide detailed analytical reports to improve the strategic governance of safety.

3.47 All prisoners could access the Samaritans via in-cell telephones and there were sufficient Listeners, although some reported lack of staff support to see prisoners in crisis, especially at night. It was positive that Listeners could attend weekly support sessions with the Samaritans.

**Protection of adults at risk (see Glossary)**

3.48 Adult safeguarding arrangements were much improved and there was an appropriate focus on them from prison leaders in partnership with social care leads from the Practice Plus Group (PPG). There were established links with the local safeguarding adults board, including attendance at online meetings.

3.49 The prison made use of the PPG safeguarding adults policy which, while not Pentonville-specific, provided useful guidance for senior leaders. Safeguarding was being promoted to raise awareness among prison staff, starting with a useful easy-read document that described the principles of adult safeguarding with a range of contact details for local authorities.

3.50 There had been 12 safeguarding referrals to external agencies and local safeguarding adults boards in the previous year. We were given several examples of tailored case management for prisoners who required additional safeguarding support; these were appropriate and effective in improving individual outcomes for those at risk.

# Section 4 Respect

**Prisoners are treated with respect for their human dignity.**

## Staff-prisoner relationships

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

4.1 We saw some evidence of good staff-prisoner relationships, but also many examples of rude and dismissive behaviour by staff and minimal interactions with prisoners. In our survey, only 58% of prisoners said they were treated with respect by most staff compared with 68% at similar prisons; and 41% said they had experienced verbal abuse from staff compared with 31% in similar prisons (see paragraph 3.10).

4.2 Key work was functioning for very few prisoners and sessions had only recently been delivered to a small number. In our survey, only 33% of prisoners said they had a named key worker compared with 74% in the last inspection, and only 23% said they had been asked how they were getting on in the last week. A dedicated key work lead had recently been identified to drive this work forward, but it was too early to see any outcomes for prisoners.

4.3 We witnessed poor prisoner behaviour going unchallenged, including the obvious use of illicit substances (see paragraph 3.35). Many staff complained about a lack of confidence in some aspects of their role and a lack of training. Those on duty during our night visit did not have up-to-date mandatory training. Well-received short in-house sessions had been introduced earlier in the year to address such concerns, including training on document completion and working with prisoners with mental health issues.

## Daily life

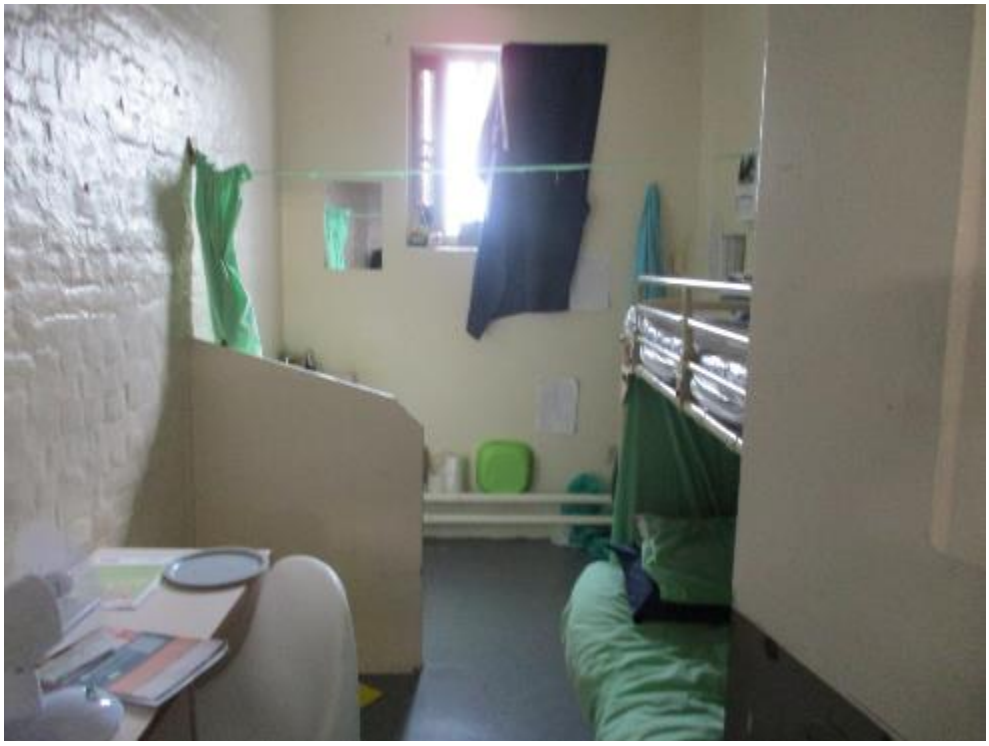
Expected outcomes: Prisoners live in a clean and decent environment and are aware of the rules and routines of the prison. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient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

### Living conditions

4.4 Living conditions remained cramped and many cells were not big enough for two prisoners sharing. Prisoners continued to improvise with screening in-cell toilets and there were many complaints about the ongoing cockroach infestation. The ventilation in cells was poor,

especially in those with new vented windows that could not be opened, and many were extremely hot, especially on the higher landings. On two occasions we saw occupied cells that were meant to be out of use and contained no furniture other than beds. Wing staff were aware of this but took no action until we raised it.

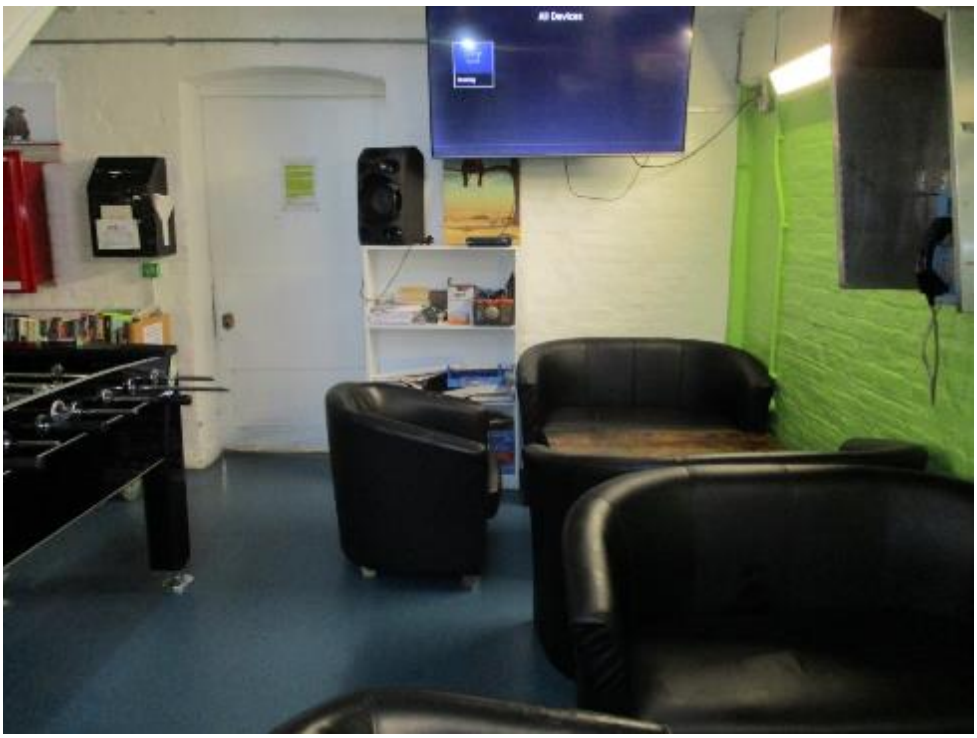
**Out of use cell holding prisoners**



**Cell with improvised toilet screening**

4.5 There were insufficient showers and in our prisoner survey, only 28%, against the comparator of 69%, said they could shower every day (see also paragraph 3.5). Some showers had been refurbished, but many remained inadequate.

4.6 Communal areas were cleaner than at the last inspection and leaders continued to drive forward the monthly decency checks, although staff did not always complete daily checks on the units. There was a refurbishment plan and some areas had seen some improvements, including the first landing on G wing that was due to reopen soon. Prisoners on J wing had a communal area with a TV and soft furnishings, which they appreciated.



**J wing communal area**

4.7 Although there had been slight improvements in staff response times to cell call bells, they were still not answered within five minutes on most wings. We saw them ringing without answer on many occasions during the inspection.

4.8 Prisoners had problems in accessing their stored property, which was the subject of the highest number of their complaints (see paragraph 4.13). The prison was working on reducing the time it took for prisoners to receive their belongings.

## Residential services

4.9 Despite our previous recommendations, meals continued to be served far too early. We saw lunch served around 10.30-11am, and the evening meal from 4pm. Breakfast packs were issued with lunch the day before, earlier than at the last inspection. Prisoners told us they would often eat this with their lunch, providing a lengthy gap between the evening meal and lunch the following day.

4.10 In our survey, only 28% of prisoners said the quality of food was very or quite good. The gap in prisoner forums (see paragraph 4.15) meant that there were no current consultations with prisoners about the food. Equipment in the kitchen was waiting to be repaired and kitchen staff told us this affected some of the food they were able to provide at mealtimes.

4.11 Most prisoners had no option but to eat in their cell, except on J wing where tables were provided in the communal areas. Self-catering facilities were also only available on J wing and greatly appreciated by

prisoners; they were able to buy additional items from the prison shop to prepare in the wing kitchen.

4.12 There had been recent major problems with the prison shop, including items missing from orders and food that was out of date by the time it was delivered. This had caused much prisoner frustration, but the prison was making good progress in addressing their concerns.

### Prisoner consultation, applications and redress

4.13 Prisoners had little confidence in the complaints process. In the sample of complaints that we reviewed, some had no responses to the prisoner at all and detail was lacking in replies. Quality assurance had only recently restarted. Although trends were identified, ongoing problems remained, including delays in prisoners receiving their property, which was highlighted as an issue month on month (see paragraph 4.8). However, the leadership team identified those departments that had a slower response rate and timeliness had started to improve.

4.14 Wing Insiders continued to help prisoners make applications. Some used an application logbook and chased the response, but on one wing Insiders had only received a logbook during the week of our inspection.

4.15 Consultation with prisoners had only restarted in the previous week, following a gap since March 2022. A 'prisoner platform group' had taken the place of the previous prison council and was so far the only consultation in place.

4.16 The library had a good selection of legal books and twice a month held a legal advice session delivered by the Prisoners' Advice Service, but the inability to mix wings in the library (see paragraph 5.4) could delay prisoner access. In our survey, only 33% of prisoners said it was easy to communicate with their solicitor or legal representative and only 8% said this on A wing, the first night centre, compared with 38% in the rest of the prison. There was a delay in phone access for some new arrivals due to not receiving their personal identification numbers (PINs) for their contacts promptly.

4.17 A bail information officer had recently been appointed after a gap, but there was no data-sharing between this service and the prison.

## 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

4.18 As at the previous two inspections, leaders had not done enough to prioritise the promotion of equality and diversity and oversight had only recently resumed. A senior manager led on safety as well as equalities and, although supported by a dynamic equality manager, could not cover all the work.

4.19 There was some good collection and analysis of data but the equality strategy was not supported by a needs analysis or informed by local data. Around 70% of the population were from a minority ethnic background and monitoring data showed some disproportionality in relation to them and other groups, but we saw little evidence of subsequent actions. There had been no consultation or forums for prisoners with protected characteristics and equality meetings were inconsistently attended.

4.20 In the previous 12 months, 123 discrimination incident reporting forms (DIRFs) had been submitted. In the sample we reviewed, investigations were usually reasonable, but some were not sufficiently thorough and did not always involve speaking to the complainants. The Zahid Mubarak Trust was providing feedback and scrutiny of DIRFs. Analysis of DIRFs did not explore trends over time.

4.21 Leaders had advanced plans to introduce a neurodiverse unit, which would provide additional support for prisoners with neurodivergent needs.

4.22 There had been efforts to mark a wide variety of cultural events and raise awareness of different protected characteristic groups. The prison had made good use of guest speakers, displays and communications to engage with staff and prisoners.

## Protected characteristics

4.23 About a quarter of prisoners were foreign nationals. There was no coordinated provision for them and the use of interpreting services was minimal, despite evidence of significant need. There were 22 prisoners held under immigration powers after completing their sentence, and three had been detained since 2020, which was far too long. Most foreign national prisoners we spoke to told us they were confused and felt helpless regarding their immigration status. Few said they knew of the support charities, Bail for Immigration Detainees, Detention Action and Kent Refugee Help, although prisoners could contact them at no cost from in-cell phones. Home Office immigration officers were in the prison daily, but they were short-staffed and prisoners told us they struggled to find them.

4.24 In our survey, Muslim prisoners were more negative about bullying and victimisation than non-Muslim prisoners. They were also overrepresented in various areas in local data, such as adjudications, use of force and the basic level of the incentives scheme. These disparities had not yet been sufficiently explored.

4.25 There was some good support for younger prisoners. Just under a quarter of prisoners were 25 and under, 94 of whom were under 21, and both our survey and prison data showed they were over-represented in the use of force. The prison had continued to resource the Time4Change course, a bespoke and effective intervention delivered to around 35 under-25s a week. The 12-week course covered a range of topics from fatherhood to forgiveness and made good use of peer mentoring (see paragraphs 3.14 and 6.37). There were additional staff to provide analytical support, and the facilitators had a good understanding of this population at Pentonville.

4.26 Prison data indicated that around a quarter of prisoners (288) had self-declared as disabled. There were three wheelchair users in the main prison. While some improvements had been made by providing ramps, for example to exercise yards, the cramped physical environment still made it difficult for them to access other areas, such as education. There were 18 prisoners with personal emergency evacuation plans (PEEPs); some night staff lacked knowledge about the prisoners with PEEPs in their care.

4.27 There was no additional support or provision for older prisoners or most of the eight prisoners who had identified as gay or bisexual. The equality adviser had supported two transgender prisoners at Pentonville during the inspection well and had a good understanding of their needs. There were 17 identified veterans, although only four were currently receiving additional support from a volunteer from SSAFA (Soldiers, Sailors, Airmen and Families Association).

### Faith and religion

4.28 The chaplaincy played a full part in the life of the prison and, with the help of a large volunteer group, was able to offer services beyond its statutory duties and faith-based classes.

4.29 Corporate worship had resumed and in our survey 70% of prisoners said they could attend religious services, compared with only 46% in similar prisons. There was a chapel, a small multi-faith room and a mosque, although current cohorting arrangements (see Glossary) meant that Friday worship was spread between different areas.

**Chapel**

**Mosque**

4.30 The chaplaincy met all new arrivals within their first 48 hours. Prisoners could contact them on a direct line using in-cell telephones and at scheduled times on the wings to make sure they were accessible and approachable.

4.31 The chaplaincy provided the Sycamore Tree victim awareness programme and bereavement counselling session, and ran the official prison visitors scheme with 13 visitors involved. The team of volunteers provided a wealth of skills and expertise, including a chaplain who was an autism specialist and who made contact with prisoners with neurodivergent needs. Other volunteers built links with the outside community, having secured employment for a small number of prisoners, and one also carried out ACCT assessments.

## 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.

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

### Strategy, clinical governance and partnerships

4.33 There was strong partnership working between the prison, commissioners, public health and the health providers. There was good attendance at the local delivery board meetings where risks and responsibilities of all partners were managed. Health improvement plans were in place with objectives such as the new staffing model, where substantial funding had been secured to improve health services. Other joint working was evident in the oversight of pan-London prisons mental health transfers and the recent new drug-free living unit on J wing. There were credible plans to develop a neurodiverse pathway.

4.34 Governance arrangements were in place, and lessons were learned by heath staff from incidents and deaths in custody (see also paragraph 3.42). Although the contracted providers produced staff newsletters and communicated changes, training events and incidents, not all staff felt confident that they were up to speed with incident learning, but service managers had plans to improve this. There were audit programmes and medicine managements and governance meetings. We saw some good joint safeguarding work between health services and the prison.

4.35 There was a high number of nursing and health care assistant vacancies in primary care and cover was provided by bank and agency or substance misuse nurses. Staff told us that bank and agency nurses did not always hold keys, which meant that they often required support on site and could not undertake certain responsibilities; this added to the pressures on permanent staff. Recruitment plans were in place and

new models of care due to be rolled out were likely to improve the staffing position.

4.36 Existing staff received regular supervision, although had not had an appraisal in the previous 12 months. Staff training, although regular, was below expected rates for completion. A few told us workloads were high and they would like more management support. All the interactions we saw between health staff and patients were respectful and almost all prisoners said that most staff were polite.

4.37 There were some weaknesses with the quality and oversight of health complaints, but Practice Plus Group (PPG) had plans to strengthen this. There was a specific health complaints process; this was not well advertised, but all wings had post boxes and most had paper forms. Some boxes were in areas not freely accessible to prisoners.

4.38 Not all clinical space was compliant with infection prevention and control due to ripped fabric on chairs and examination couches.

4.39 Competent staff responded to medical emergencies promptly and with well-equipped emergency bags.

**Promoting health and well-being**

4.40 There was no health promotion strategy, although there was a calendar of health promotion events that reflected national programmes. Health promotion activity had been minimal although a new primary care clinical lead was now in post. There were few health information posters and leaflets in the health care centre or on the wings and no information was available in foreign languages. There was a policy on managing outbreaks of communicable diseases.

4.41 National health screening programmes, such as retinal screening and bowel cancer, had paused during the pandemic and had recently restarted. Patients had access to immunisations and vaccinations, including the COVID-19 vaccine.

4.42 A sexual health nurse held clinics four days per week, but some staff were unclear about how prisoners could access barrier protection outside of these clinics.

4.43 The health care team worked with the gym and kitchen on medically required exercise and diets for patients. A quit smoking service was no longer offered.

**Primary care and inpatient services**

4.44 Nursing staff screened new arrivals in a dedicated room in reception and made referrals to other services as part of the process. A secondary health assessment took place within seven days.

4.45 The prison did not consistently notify health care of patients coming back from court or video link, as well as after a hospital admission, which could mean that their health and well-being needs were not met.

The health care department had identified this as a concern as part of a review into a death in custody. Where the prison did inform health care, there were regular health and well-being checks on those who needed additional support.

4.46 GP and nurse clinics were available Monday to Saturday and there was emergency nurse and/or paramedic cover overnight and at weekends. Patients were seen promptly for urgent GP or nurse appointments, and routine waiting times were equivalent to the community. There was clinical oversight of triage to make sure patients were directed to the most appropriate clinical professional. But prisoners were frustrated about their access to services and interventions; in our survey, only 24% of prisoners said it was easy to access the nurse, against the comparator of 38%. Access to some service had been affected by the cohorting arrangements (see Glossary), but this was improving.

4.47 Prisoner applications for health care were not always collected and reviewed promptly, which led to delays in the triage of patients for urgent appointments. Prisoners also said that that they regularly had no response to completed health care applications, and there were some potential risks with this delay if prisoners did not know how to summon urgent help. We also identified one patient who had experienced a significant delay in being referred under the two-week wait cancer pathway.

4.48 The service had a long-term conditions nurse and staff had received training for some long-term conditions such as asthma and hypertension, with further training planned. Prisoners with long-term conditions were regularly invited for review. The national target for heart failure screening and care was not met and there was a plan to improve this. There were a range of visiting practitioners and allied health care professionals, including physiotherapist, podiatrist, optometrist as well as a sonographer Ultrasound scanning took place in the prison, and access to telemedicine appointments through the local hospital reduced some demand on external hospital escorts.

4.49 Staff kept detailed records of patients' care and treatment that were clear, up to date, stored securely and easily available to all staff. However, in the records we reviewed we identified one patient who had received sub-standard care; this was shared with the provider and a clinical incident review promptly established. The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients with additional needs to access services.

4.50 The spacious 22-bed inpatient unit had a comprehensive admissions policy, which permitted non-clinical admissions. Most patients were admitted for mental health reasons. One patient had physical health needs and a second required social care support but there was no cell suitable in the main prison. Two patients were awaiting transfer to a secure bed under the Mental Health Act.

4.51 There was medical input from a GP as well as two psychiatrists who met the patients each week. Care plans had been developed for patients, although some were process driven rather than centred on the person. Physical health needs were met for patients who needed input. There was a positive therapeutic input and the occupational health team provided daily activities for patients and were responsive to their needs.

4.52 There were suitable arrangements to care for prisoners with palliative care needs when the need arose.

### Social care

4.53 A social care protocol, under review, described the pathways for the delivery of social care in Pentonville. The local authority remained responsible for assessments and there was a single point of contact for both the prison and the domiciliary care provider, PPG. Oversight was provided at quarterly review meetings and discussed at the local delivery board. The social care provision was not advertised on the wings and not all prison staff and prisoners understood how to make a referral to the responsible authority.

4.54 Domiciliary care was provided by PPG staff and recorded on to SystmOne (the electronic clinical information system), and care plans were in place and available to all relevant staff. Care was delivered on the wings and in the health care centre.

4.55 Prisoners who did not meet the threshold for domiciliary care were given some low-level care through fellow prisoners who were selected and risk reviewed by wing staff. These carers received minimal training and there was no evidence of adequate supervision to make sure that they were not breaching boundaries or getting mentally or physically fatigued.

4.56 The prison did not have enough suitable or Disability Discrimination Act-compliant cells for the population (see paragraph 4.26).

### Mental health care

4.57 Mental health services were provided by Barnet, Enfield and Haringey Mental Health NHS Trust and included an inpatient unit, special supervision service, in reach and therapies. The service received all its referrals from the PPG primary care health and well-being team following an initial assessment, but there were delays in follow-up assessments. There were159 patients waiting up to 10 weeks for a full assessment and a further 100 waiting a further five months for one-to-one intervention. In our survey, only 19% of prisoners said that they had been helped with their mental health problem in the prison.

4.58 An effective in-reach service provided prompt and comprehensive care for those with severe and enduring mental health problems, including a range of psychiatry. Transfers of prisoners to secure beds under the Mental Health Act had increased since our last inspection from 48 to 69

in the previous 12 months with the increase in remand prisoners; 49 of those transfers had taken more than 28 days. There was now a pan-London prison health oversight group looking into mental health transfers to reduce patient waits.

4.59 A well-being unit delivered day care that included a range of therapeutic activities, including speech and language assessments and therapy. The psychological therapies team held one group a week with the remaining interventions being one-to-one sessions. There were plans to increase the number of groups. Access to therapies was prioritised for those with the greatest needs.

4.60 The mental health record-keeping notes we viewed were good quality and patients on the caseloads had comprehensive assessments, plans of care and risk identified.

4.61 The enhanced support service supported a small number of prisoners with unusually high levels of challenging behaviours (see paragraph 3.15).

4.62 Many of the teams across mental health and substance misuse services who were delivering therapies had very limited access to bookable interview rooms where they could deliver care without interruption, which wasted time and led to lost appointments.

4.63 There was training for prison officers working on the specialist units and further training was being rolled out to core staff.

4.64 Physical health checks for mental health patients were in place and patients recalled as required. The mental health team did not record information about their waiting lists and caseloads in a way that could be shared with the whole health care team.

**Substance misuse treatment**

4.65 There was a comprehensive drug strategy. Clinical prescribing was in line with national guidelines, although there was no overnight monitoring for new arrivals withdrawing from drug use. We spoke to one patient who had been withdrawing and had requested assistance but due to staffing pressures did not receive a visit. There were 123 prisoners receiving opiate substitution therapy.

4.66 Patients with substance addictions were referred through the health and well-being team. Those allocated to the substance misuse service team were seen clinically if required and then placed on a waiting list for caseload allocations, which took about two weeks. There were currently five vacancies in the psychosocial team, which affected the frequency of interventions.

4.67 Psychosocial assessments were undertaken within five days and most include a comprehensive review of risks and mitigation. Assessments were now face to face but, due to the lack of space to do this directly on to the clinical information system, information was uploaded later,

which was not time effective. The substance misuse service also used databases on desktops to monitor caseloads rather SystmOne.

4.68 A range of psychosocial interventions were used to address substance misuse. Groups were held for prisoners on wings, and J wing was a newly established drug-free living area (see paragraph 3.19).

4.69 A full-time family worker and community link worker provided excellent links with relevant external organisations for prisoners. There was limited discussion between the link worker and internal mental health caseworkers, but care of those with dual diagnosis being released was discussed with community mental health services.

4.70 Mutual aid provided by groups such as Alcoholics Anonymous and Narcotics Anonymous was regular and well attended but needed to be facilitated by the drug workers due to the lack of security clearance for volunteers attending to deliver the groups.

**Medicines optimisation and pharmacy services**

4.71 Medicines were supplied by PPG through an internal pharmacy. The medicines in-possession policy was up to date and risk assessments were reviewed regularly. At the time of the inspection, only 33% of prisoners had their medicines in possession. Cells still lacked lockable facilities for storing medicines. Most medicines for new arrivals were reconciled on their reception.

4.72 On-site pharmacists screened prescribed medicines and medicines were administered on the wings twice a day by pharmacy technicians and nurses. The queues for medicines administration were adequately supervised.

4.73 Out-of-hours medicines were available for administration by the nurses. A special sick policy enabled access to a range of over-the-counter medicines, including pain relief. Supplies of medication were documented on SystmOne.

4.74 Medicines were transported safely in lockable boxes. Pharmacy storage cupboards were very full and none were lockable. The room and fridge temperatures were monitored. Controlled drugs were stored in line with the standards. The pharmacy room was grubby and required a deep clean.

4.75 There were monthly medicines management meetings, which included review of incidents, alerts and prescribing. There were up-to-date standard operating procedures and an agreed formulary.

**Dental services and oral health**

4.76 Two separate dental services provided dental treatments, which were heavily concentrated on urgent or emergency care and pain management. The health care and dental teams triaged patients and offered pain relief for those awaiting an appointment if required.

4.77 Waiting times for appointments were between two and six weeks. The dentist promoted oral health for those who needed it, and the dental nurse gave advice on how to minimise deterioration in the health of teeth and gums, which was well documented in patient records. The care records we reviewed showed that while the treatment provided was well documented, the choice offered was not always clear and justification for X-rays not consistently recorded. A recent audit by one of the services had developed an action plan about this.

4.78 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.

# 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 To avoid gang and other conflicts, the prison kept prisoners in set cohorts when they attended activities requiring movement off their wing. This minimised the mixing of prisoners between wings and affected their ability to attend activities. Our roll checks suggested that around a quarter of prisoners were engaged in purposeful activity during the core day and 40% were locked in their cells. These figures were unreliable as wing staff could not always account for the whereabouts of prisoners (see paragraph 3.38).

5.2 Prisoners who were unemployed had only one to two hours a day out of cell, while those in activity usually had three to six hours a day, depending on whether they worked full or part time. Prisoners on the drug-free wing were unlocked during the core day.

5.3 There were frequent slippages in unlock times and regime curtailments were common. Prisoners were frustrated by the lack of a predictable regime; on 17 of the previous 43 days, at least one unit had faced some regime curtailment. Many prisoners told us they had gone days at a time without showers (see paragraph 4.5). They were always locked up on Saturdays when their shop orders were delivered, which meant that they might not be given showers or time in the fresh air for 48 hours.

5.4 The library remained a good environment, although only prisoners on G wing had regular access as a result of the current cohorting arrangements. Prisoners on other wings had a small collection of books and a delivery service when requested. Library orderlies had been employed to support the wing-based function but were not currently based on every wing.

5.5 The library's good range of resources included a high number of foreign language books and up-to-date legal materials. The library held a twice-monthly legal advice session delivered by the Prisoners' Advice Service (see paragraph 4.16). The library also offered 'Family Fables', where a prisoner could record a story book for their children. Shannon Trust mentors supported prisoners with reading and creative writing classes, but most of these sessions were on a rolling programme for wings to attend and it took too long to provide access to all prisoners.

5.6 Prisoner access to the gym was poor and, although the timetable identified two sessions a week each, only 13% in our survey said they attended for this amount of time. Sessions were often cancelled due to the inability to mix wings and staffing shortages. The gym was well regarded by prisoners, but many told us they wanted more access.

5.7 There were still three well-equipped gyms, but the sports hall had been out of use for some time due to a flooring problem. This had affected the provision of other sporting activities and participation by external agencies who had previously attended. Exercise yards varied across the prison and outdoor exercise equipment was not currently available to all prisoners due to some maintenance work.

5.8 Remedial gym sessions had only recently restarted. There were currently no specific sessions for prisoners with substance misuse issues, and the gym no longer collecting any data on those accessing the facilities.

## 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.

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

Overall effectiveness: inadequate

Quality of education: inadequate

Behaviour and attitudes: requires improvement

Personal development: requires improvement

Leadership and management: inadequate

5.10 New arrivals were quickly provided with an introduction to the education, skills and work opportunities available to them. They underwent a thorough assessment of their English and mathematics knowledge and any potential learning difficulties and/or disabilities. They also received an initial advice and guidance interview to determine their career aspirations. However, in too many instances this information was not used sufficiently well to allocate prisoners to accommodation that enabled their access to the appropriate education, skills and work.

5.11 Prison leaders had provided enough activity places for all prisoners. However, due to the restricted regime, education, skills and work opportunities were limited by the accommodation wing where prisoners resided. This meant that there were significant inequalities in the range of activities available for them. For example, some prisoners only had access to English courses or level 1 painting and decorating, whereas others could attend a much fuller range of activities. This resulted in many prisoners being unable to access their preferred course and only half of the available activity places being used. Consequently, prisoners became disengaged and lacked motivation for their studies.

5.12 The majority of work available to prisoners was based on the accommodation wings and was mostly in cleaning or painting roles. However, the allocation of prisoners to these jobs was not done by the central allocations team but by prison officers. In most cases, officers did not consider prisoners' prior knowledge and skills or career aspirations when doing so. This led to frustration among prisoners when they saw new arrivals getting jobs before those who had waited longer. Leaders and managers recognised this inequity but had been slow to rectify it.

5.13 A few prisoners who were allocated to education, skills and work developed practical skills to a high standard, which supported them to gain employment on release. Prisoners on the barista course, supported by a coffee company, received training to an industry standard. They developed their knowledge of the coffee bean roasting process well, which helped them to explain to customers the different flavours. Prisoners in the staff canteen produced food that was healthy, appetising and popular with prison staff. Prisoners in the textiles workshop made underwear to a high standard as part of a prison service contract. However, in none of these areas did prisoners gain accredited qualifications that demonstrated their skills and knowledge. In too many areas, for example the kitchens and waste management, prisoners did not receive basic certification, such as food safety and food hygiene or health and safety, but had a briefing from a member of staff instead. This limited their ability to gain employment once released or if transferred to another prison.

5.14 Prison instructors did not use the information about prisoners’ prior knowledge to plan personalised training. This meant that, regardless of a prisoner’s level of skill, they all followed the same training. As a result, the more experienced prisoners were often bored.

5.15 Most tutors in education planned lessons well. They used a range of strategies to help prisoners develop their knowledge. For example, tutors teaching peer mentors used role play effectively to help them develop their listening skills, be non-judgemental and improve their empathy. This enabled the small number of peer mentors to be effective in their roles. In art, the teacher made skilful use of a range of cultural artefacts to help prisoners learn about the history of tattoos; they applied this knowledge well to their own tattoo designs. However, in mathematics lessons, tutors' planning was less effective. This was in part due to the wide range of abilities of prisoners in the group and contributed to them not developing their knowledge and skills sufficiently well.

5.16 Too many tutors did not use the information available on prisoners' additional learning needs. This resulted in strategies to support prisoners not being used and the support necessary not being put in place. Consequently, prisoners did not receive the support they needed.

5.17 Tutors' feedback on prisoners' work did not help them to improve. For example, in mathematics, errors had not been corrected. This resulted in prisoners continuing to use inaccurate calculations and led to frustration and disengagement when they could not achieve the correct answer. In other lessons, tutors' feedback was little more than a series of ticks and crosses. There was little explanation that would help the prisoner to improve their work by understanding where they had gone wrong.

5.18 Prisoners' attendance and punctuality in education were poor. Often half of the expected prisoners did not attend lessons. In a few instances, prisoners were told lessons were cancelled when they were not. This resulted in tutors and prisoners being frustrated. The prisoner pay policy did not offer a financial incentive to attend education, and leaders and managers prioritised work through higher rates of pay and weekly bonuses. As a result, attendance at work activities was better.

5.19 The curriculum for English and mathematics functional skills and English for speakers of other languages (ESOL) was unambitious. Tutors did not have high enough expectations of prisoners. As a result, very few achieved their qualifications and almost none progressed to higher study.

5.20 In textiles and the staff canteen, instructors had high expectations of prisoners. They were passionate about the skills prisoners developed and demanded high-quality work. For example, in textiles, prisoners quickly learned how to measure and cut accurately, how to use a wide variety of stitches, and how to hem evenly. In the staff canteen, prisoners produced food which was well regarded by prison staff. As a result, prisoners were keen to learn and made rapid progress in developing their skills and knowledge.

5.21 Leaders and managers did not have sufficient links with employers to support the high number of remand prisoners. This limited the

effectiveness of staff in helping prisoners due for release to gain employment. The business advisory board had recently been set up to rectify this deficit, but this was still in its infancy and did not yet have any benefit to prisoners.

5.22 Leaders and managers understood the challenges faced by the restricted regime and the impact this had on the quality of education. They had some early plans of how they could improve access to education, skills and work, but these were still in development. However, leaders and managers did not have a good enough understanding of the quality of activities provided by the prison. Existing quality assurance arrangements did not extend to prison activities. This resulted in a lack of focus on prison activities, and actions to improve the quality of education, skills and work did not happen quickly enough.

5.23 Most prisoners in education, skills and work understood what it was to be a responsible citizen. They were very polite and respectful to their peers and tutors, often thanking others when they helped them. Prisoners who became peer mentors, Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) or other roles of responsibility took pride in the work that they did in helping others. They could discuss how they demonstrated tolerance with prisoners in lessons and they were proud to help their peers on their wings.

5.24 Prisoners behaved in a manner consistent with the fundamental values of respect and tolerance. In lessons, they learned to take it in turns to speak, not to interrupt, and to listen to the views of others. When prisoners took part in discussions and debates, they demonstrated respect for each other's views and opinions. Most prisoners helped each other if they needed it. For example, in textiles, they helped others with the tensioning of the thread in the sewing machine. However, there was too little evidence that prisoners had an in-depth understanding of democracy, the rule of law and individual liberty through their taught sessions.

5.25 Prisoners did not have sufficient support during their sentence to understand the careers available to them on release. As a result, too many, particularly those in the prison long term, did not have adequate 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.

5.26 Vulnerable prisoners did not have access to a wide enough range of activities, and fewer than prisoners on other wings. Their only available work activity was outdoor cleaning and they were offered education only in mathematics. As a result, they did not develop the skills needed to help them once released from prison.

5.27 Prisoners on J wing benefited from a broad range of activities that helped them to develop skills that would support them in their future lives. For example, they had a chess club which had grown in

popularity. Prisoners could explain how they learned to be patient and more strategic in thinking ahead and anticipating how others were thinking. There were plans to implement these activities across the other wings, but these had not yet happened.

# 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 Prisoners and their families reported problems booking visits on the national booking line, with very long delays before staff answered telephone enquiries. Visits only lasted one hour but generally started on time. There were insufficient weekend visit places, although these were due to be doubled.

6.2 The visitors' centre was run by the charity PACT (Prison Advice and Care Trust). It had been refurbished since the last inspection and was now in reasonable condition. PACT staff were welcoming and provided good support to families and their children, including those visiting for the first time. There was an appropriate focus on ensuring children had a positive visits experience.

**Visits hall**

6.3 Facilities in the visits hall were reasonable and much improved since the last inspection; the children's area was unsuitable but was being developed. A PACT playworker was now available during all visits. There was a pleasant area for family visits, which gave children more opportunity to move around. The refreshment bar had been refurbished and was now in reasonable condition, but provision was still limited to unhealthy snacks, mainly chocolate bars, crisps and fizzy drinks; there was no fresh food, tea or coffee available.. The prison was due to resume family visits days, which had been suspended since the start of the pandemic. Prisoners and visitors we spoke to said they were treated with respect. A recent visits questionnaire that PACT had encouraged visitors to complete raised no concerns about staff.

6.4 Prisoners could still book video calls with their family and friends through the secure video calls scheme (see Glossary) and the facility was widely used.

6.5 PACT provided good support through its family engagement worker. It had just employed a family relationship tutor to support prisoners complete in-cell packs covering family relationships, parenting and anger management. Forward Trust provided a family support worker to help the families of prisoners with substance misuse issues.

6.6 Prisoners now had in-cell telephones, which facilitated much better family contact, and the 'email a prisoner scheme' was well used. The handling of prisoner mail was adequate.

## 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.

6.7 The profile of the prison population had changed since our last full inspection due to the impact of COVID-19 and delays in the criminal justice process - 46% of prisoners were on remand, double the percentage at our last full inspection, and only 20% were sentenced compared with 50% last time.

6.8 The reducing reoffending and resettlement strategy for 2021/22 was weak. The last needs analysis had been completed in 2019 when the population was very different. The strategy did not reflect challenges of working with what was now a very high remand population or other relevant factors, such as the high number of young adults and black and minority ethnic prisoners. A new needs analysis was due in August 2022. There was now a basic action plan, but it needed to be developed to drive improvement in provision.

6.9 There had been poor attendance at strategy meetings, but this had been improving recently, although there had still been no representative from the offender management unit (OMU). Oversight of the work of partner agencies was also improving, and better flow of information on their work was helping the focus of meetings.

6.10 It had taken too long for the prison to identify major deficiencies in the performance of the OMU, which had suffered from poor leadership, oversight and a failure to maintain basic processes essential to its functioning.

6.11 There were long delays, sometimes extending to months, in the OMU's response to applications and complaints, completion of sentence calculations and other key functions. There was no record of any OMU meetings in the last 12 months and little data had been collected on the performance of the team. These failings resulted in many major problems, including the release of three prisoners in error in 2021 and another in May 2022.

6.12 Two managers had recently been seconded to the prison until November 2022 to address the identified concerns. Some promising data indicated improvements in the performance of the team and basic processes. However, much more needed to be done to ensure the effective running of the unit and the integrity of data on which its performance could be assessed.

6.13 We had confidence in these managers and in the senior probation officers, but the latter were also employed on temporary contracts. Improvements were fragile and also threatened by staff shortages and poor staff morale. We were concerned that changes in leadership

personnel might come too soon to complete and embed remedial action.

6.14 All sentenced prisoners now had a prison offender manager (POM). Although caseloads were low, 13% of prisoners did not have an initial OASys (offender assessment system) assessment, and 15% of assessments had not been reviewed in the last year. We saw some good case management, but overall, its quality was variable and in many cases was not good enough.

6.15 There were delays in the allocation of work to offender managers, leaving risk unassessed for too long. Until recently, prison offender managers had been managing high risk cases without probation support or supervision. In most cases, there was little evidence of any structured work with prisoners.

6.16 The team had resumed face-to-face contact with prisoners where needed, for example for OASys assessments. However, prisoners expressed frustration that they could not see relevant staff to support their progression. There were no OMU wing surgeries and no prescribed minimum frequency of contact between offender managers and prisoners. As at the last inspection, too much contact was reactive and only made to address milestone events, such as recategorisation and OASys assessments.

6.17 Staff shortages in the London Probation Service were causing substantial problems, which made work with some boroughs particularly difficult. The key worker scheme was not functioning and there was little evidence that wing staff were actively assisting prisoners with sentence and release planning.

6.18 There had been very long delays with the assessment of prisoners for home detention curfew (HDC). In the last 12 months, 423 prisoners who were fully eligible for HDC were submitted for consideration, but the prison had considered only 132 cases and most eligible prisoners had been transferred or released before their case could be assessed. Poor record-keeping meant it was not possible to quantify the extent of the problem. However, a new HDC clerk had been appointed and processes and record-keeping appeared to be working much better, although more improvement was required. At the time of inspection, 19 cases were past their HDC date – 10 for over a month, with the longest for 115 days. The delays were mostly due to matters outside the prison's control, such as the late allocation of community offender managers, problems securing police approval of arrangements, and the lack of available accommodation. It remained a concern that HDC was granted to little over one half of prisoners considered for release.

6.19 There was limited provision for the 17 prisoners serving life sentences, despite some on recall spending a long time in Pentonville.

## Public protection

6.20 About one half of prisoners were assessed as presenting a high or very high risk of serious harm to others. Processes for managing such prisoners had been dysfunctional, with little management oversight. Few new prisoners had been screened to identify public protection concerns, leaving little confidence that risks were identified and managed appropriately.

6.21 Delays in sentence calculation and categorisation meant it took far too long to allocate cases to offender managers. Prison staff were managing some high-risk prisoners without a proper understanding of the risks they presented.

6.22 The new seconded managers had begun to address these problems, which were slowly improving. They recognised that staff needed further support and training to make sure they were working effectively.

6.23 We were told the interdepartmental risk management meeting had been meeting monthly, but this was seldom minuted, and provided little assurance of appropriate sharing and consideration of risk information. The meeting was relaunched shortly before the inspection.

6.24 There had been poor recording of MAPPA (multi-agency public protection arrangements) cases in prison records, and efforts were ongoing to identify all such cases. There was little assurance that MAPPA management levels were confirmed in good time before release. Senior probation officers were checking all cases three months before release to make sure none were missed. Although risk was appropriately identified in MAPPA F assessment forms, it was not always clearly presented.

6.25 At the time of the inspection, 16 prisoners were subject to mail and phone monitoring, although we were not satisfied that the prison had identified all prisoners who should be considered for it. Mail and telephone monitoring arrangements were generally well managed. However, telephone calls and correspondence that were not in English were rarely translated and left unmonitored.

## Categorisation and transfers

6.26 Oversight of categorisation and transfers had been inadequate. There had been some long delays, in some cases extending to months, in initial categorisation and this was contributing to delays in the allocation of cases to offender managers and the completion of OASys assessments.

6.27 Staff had recently been trained in their role and processes to administer categorisation were being put in place. There was evidence that the very long delays in categorisation were reducing, but they were still taking too long.

6.28 At the time of the inspection there were 188 category C prisoners, almost all of whom were awaiting transfer. There had been 515

progressive moves in the last three months, which indicated that processes were now working more effectively.

6.29 Recategorisation was not always timely. It was largely a file-based exercise, with limited face-to-face contact with prisoners. Processes had been put in place to improve prisoner's contribution to recategorisation reviews.

## Interventions

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

6.30 The unification of probation services had been a particular problem in provision of the resettlement services available. Key interventions, such as the provision of accommodation, were only funded for sentenced prisoners, leaving the very high proportion of remand prisoners with limited services.

6.31 The pre-release team (see below) undertook some limited additional work for relatively small numbers of remand prisoners, such as helping them obtain identification papers and opening bank accounts. Some voluntary organisations attending the prison also provided some similar support. The prison was funding a post to extend this provision soon.

6.32 In our survey, 69% of prisoners said they needed help with accommodation but only 24% said they were getting this. There was little support for remand prisoners with accommodation needs. Prison data indicated that almost one half of prisoners had no recorded accommodation on their first night of release.

6.33 St Mungo's (a homelessness charity) provided some accommodation support, but only to sentenced prisoners being released on licence. In the last 12 months, St Mungo's had assisted only about one in five prisoners being released.

6.34 In our survey, only 22% of prisoners said they were getting the financial support they needed, despite 70% saying they needed it. There was no longer a finance, benefit and debt worker. The Jobcentre Plus team provided some very effective support to prisoners, including those on remand, which included help to sustain accommodation, make benefits appointments and linking prisoners with work coaches.

6.35 Despite provision to help prisoners secure employment on their release, in the last 12 months only 8% of prisoners were released with jobs to go to. Release on temporary licence (ROTL) was not used as a rehabilitative intervention.

6.36 Pentonville was a local prison and there were no accredited programmes, which meant that little offence-based risk reduction work could take place before prisoners transferred out. Probation POMs had engaged in some one-to-one work with prisoners to address their

offending behaviour, but this was limited by the transient nature of the population and delays in sentencing.

6.37 There was a range of non-accredited short-term programmes, such as Sycamore Tree victim awareness. Programmes run by Time4Change (see paragraph 4.25) and Only Connect (aimed at prisoners under 28) were particularly good and well attended. Forward Trust provided group and programme work to prisoners with substance misuse issues. Prisoner access to some interventions was limited by the need to control gang violence.

6.38 Prisoners under 21 accounted for 29% of the population and there were 37 care leavers. There was some very good support for younger prisoners from partner agencies and Time4Change, but otherwise provision was limited, which the prison recognised needed developing. There was no additional support given to care leavers.

6.39 There was no longer a worker to support prisoners who had been the victims of sexual or domestic abuse.

## 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.

6.40 The demand for resettlement services was high but following changes to contracting after the unification of probation services, there was now little funded practical support for the high number of prisoners on remand.

6.41 On average 80 prisoners a month were released in the last year. Most prisoners stayed at Pentonville for only a short time: 84% of the sentenced population had been there for three months or less. There was often, therefore, limited time to assess and refer prisoners for resettlement support.

6.42 The new pre-release team had been hit by chronic staff shortages, with only two out of eight in post. The team was working at an impressive rate, prioritising the drafting of resettlement plans and their review 12 weeks before release. In the five months to the end of April 2022, 75% of initial plans had been completed. Twelve-week reviews had been affected by additional matters beyond the control of the team, such as the impact of delays in sentencing, and the team had only completed 46% of reviews. Although we saw some good planning, it was often unclear whether community offender managers followed through referrals to make sure actions had been completed.

6.43 Prison data indicated that almost one half of prisoners had no recorded accommodation on their first night of release and only 8% had a job to go to, factors which seriously undermined work to address offending behaviour and other resettlement planning.

6.44 There was no longer a resettlement board to discuss impending releases. The prison no longer ran a departure lounge to support prisoners being released and to make sure they knew where they were going. There was no structured support to check that prisoners had what they needed on release.

6.45 Through-the-gate mentoring support was available for a small number of prisoners through organisations such as Forward Trust and Only Connect.

# Section 7 Summary of priority and key concerns

The following is a list of the priority and key concerns in this report.

## Priority concerns

1. **A high proportion of prisoners said they felt unsafe and in our survey over half said they had experienced some form of victimisation from staff.**

2. **There had been seven self-inflicted deaths since the last full inspection and support for prisoners in crisis was not good enough.**

3. **The prison was severely overcrowded and it could not decently or safely care for the number of prisoners it was currently required to hold.**

4. **The high number of prisoners with low-level mental health needs had long waits for appointments and few prisoners in our survey said they had been helped with their mental health problems.**

5. **Time out of cell was poor for most prisoners.** There were frequent regime curtailments, attendance and punctuality at activities were poor, most prisoners could not visit the library and they had inadequate access to the gym.

6. **Prisoners did not receive sufficient or equitable access to a broad range of education, skills and work based on their needs.**

7. **There were serious deficiencies in the performance of the offender management unit, including work on public protection. There had been some recent progress to address this concern, but it was fragile and depended on temporary staff remaining in post.**

8. **There was little funded resettlement support for almost one half of prisoners who were on remand, affecting their access to release accommodation and other resettlement services.**

## Key concerns

9. **Fewer than half of new arrivals said they felt safe on their first night in custody, and the management of risks was undermined by safety interviews that did not take place with sufficient privacy and the lack of first night checks for most prisoners.**

10. **There was a high level of illicit drug use and staff did not consistently challenge the use of drugs.**

11. **Body-worn cameras were not well enough used and footage from CCTV and body-worn video cameras was not retained beyond a month to inform learning and improve practice.**

12. **Meals continued to be served too early and with lengthy gaps between mealtimes. We saw lunch served from 10.30–11am and the evening meal from 4pm. Breakfast packs were handed out at lunchtime the day before they were to be eaten.**

13. **There was insufficient support for prisoners from protected groups, including the large population of foreign nationals.**

14. **The primary care health service had a high nursing vacancy rate and not all agency staff had access to keys, which limited the duties they were able to carry out independently.**

15. **There was too much variation in the quality of teaching across education, skills and work.**

### Care Quality Commission regulatory recommendation

Providers must have a suitable system in place to ensure patients receive safe care and treatment and that avoidable harm or risk of harm is prevented.

# Section 8 Progress on recommendations from the last full inspection and scrutiny visit reports

## 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, risk assessment on arrival was reasonable, but first night cells were not always prepared and induction did not reach all prisoners. Violence was high and the management of violence reduction work was inadequate. Use of force was high and governance was very poor. The segregation regime had improved, but reintegration and care planning was underdeveloped and some cells were in a poor condition. The management of security was improving, but weaknesses remained; in particular, drug supply reduction work had taken too long to progress. There had been four self-inflicted deaths since the previous inspection. ACCT support processes remained weak and a large number of PPO recommendations had not been achieved. Outcomes for prisoners were poor against this healthy prison test.

#### Key recommendations

Physical security should be enhanced through the prompt replacement of windows and installation of CCTV coverage where necessary.
**Achieved**

A suitably resourced safer custody team should work proactively and collaboratively with other departments in the prison to reduce levels of violence. This violence reduction work should include prompt investigations into incidents of violence and suitable interventions to manage perpetrators and support victims.
**Achieved**

Managers should ensure that regular and effective scrutiny is undertaken of key safety processes, including violence reduction, segregation, adjudications and use of force. This should be underpinned by the review of routinely collected reliable and comprehensive data.
**Not achieved**

Use of force should be accountable. Use of force documentation, video footage and incidents involving use of batons should be routinely reviewed and lessons learned; this should be overseen by regular and well attended use of force meetings.
**Achieved**

Prisons and Probation Ombudsman recommendations should be fully implemented and subject to continuing and repeated reinforcement.
**Not achieved**

Robust management of ACCTs should include consistent case managers who take ownership of cases and provide continuity of care, multidisciplinary reviews and a robust quality assurance process.
**Not achieved**

The prison should implement a supply reduction strategy, which is overseen by a multidisciplinary team at regular meetings. Action planning should ensure that all facets of the strategy, such as intelligence-led drugs testing, are carried out efficiently.
**Partially achieved**

**Recommendations**

First night cells should be clean and well equipped.
**Not achieved**

There should be clear structures and mechanisms to identify, manage and support the reintegration of prisoners who choose to self-isolate.
**Not achieved**

Adjudications should be completed thoroughly, fairly and with no unnecessary delay.
**Achieved**

Segregation review boards should always be multidisciplinary and should focus on care and reintegration planning.
**Not achieved**

Security intelligence should be acted on promptly.
**Not achieved**

## Respect

### Prisoners are treated with respect for their human dignity.

At the last inspection, in 2019, many prisoners reported that staff did not treat them with respect and there was not enough proactive management or care of prisoners. The prison was overcrowded, had suffered from underinvestment and was in a generally poor physical state. Applications were not managed consistently well. The management of complaints was improving but not yet sufficiently good. Prisoner consultation was weak. Equality and diversity work had been neglected until recently. Not enough

was done to understand and meet the needs of the large population of younger prisoners and those with disabilities. Work with the substantial population of foreign nationals was better than we usually see. Faith provision was very good. Health services were very good overall and mental health provision was particularly impressive. Outcomes for prisoners were not sufficiently good against this healthy prison test.

**Key recommendations**

Managers should ensure that staff behave respectfully towards prisoners, actively supporting them and challenging poor behaviour, in line with the principles of a rehabilitative culture.
**Not achieved**

Cells should provide decent and hygienic conditions, including properly screened toilets and sufficient space for each occupant.
**Not achieved**

The new equality strategy should cover all protected groups and be overseen by regular equality meetings to ensure effective implementation. It should include actions in relation to effective consultation, analysis of monitoring data and prompt response to diversity complaints.
**Not achieved**

The prison health care local delivery board should ensure that assertive action is taken to enable access to health care, safe storage of in-possession medicines, and a prison-wide strategy for health and well-being.
**Not achieved**

**Recommendations**

Prisoners with disabilities should not be held in Pentonville if they are unable to access readily outdoor exercise areas and key provision, such as work and education.
**Not achieved**

Showers should be clean and hygienic.
**Not achieved**

Cell bells should be answered within five minutes.
**Not achieved**

Breakfast should be served on the morning it is eaten, lunch not before noon and the evening meal not before 5pm.
**Not achieved**

Prisoners who need it should have access to bail information and support.
**Achieved**

Governance procedures should be strengthened significantly to ensure safe and appropriate social care provision.
**Not achieved**

Patients requiring care in external mental health services should be transferred expeditiously.
**Not achieved**

Maximum and minimum temperatures should be recorded daily for refrigerators where medicines are stored and documented corrective action should be taken when temperatures fall outside the 2-8 degrees centigrade range.
**Achieved**

## Purposeful activity

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

At the last inspection, in 2019, the predictability of the regime had recently improved, but prisoners had too little time out of cell. The library provided a good service. Access to the gym was not good enough for most prisoners. Progress in improving learning and skills provision had been slow and vulnerable prisoners still had a very limited range of education. There were enough part-time activity places for all prisoners but, despite recent improvement, attendance remained poor. When they attended, prisoners behaved well. Teaching was mostly effective but poor in mathematics. Achievements were high on most courses. Outcomes for prisoners were not sufficiently good against this healthy prison test.

### Key recommendations

Managers should ensure that all prisoners have the opportunity to participate in a full and purposeful regime and are encouraged to attend activities.
**Not achieved**

Prison-wide quality assurance processes should be developed to ensure an effective approach by prison managers to self-evaluation and planning for improvement across all education, skills and work.
**Not achieved**

### Recommendations

Vulnerable prisoners should have access to a wide range of education, skills and meaningful work.
**Not achieved**

Managers should provide structured support for prisoners with specific additional learning support needs.
**Not achieved**

All prisoners should receive good quality teaching in functional skills English and mathematics, leading to successful achievement of qualifications.
**Partially achieved**

Managers should collect and analyse data on prisoners' life after release to ensure that the activities offered meet their needs.
**Not achieved**

## Rehabilitation and release planning

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

At the last inspection, in 2019, family support work was limited and there were significant shortcomings in visits provision. The strategic management of rehabilitation work was weak and joint working between departments was poor at the time of the inspection. Most eligible prisoners did not have an up-to-date assessment of risk and needs. Offender management work was too reactive and little work was undertaken throughout the sentence. Public protection procedures were reasonable overall, but the lack of multidisciplinary risk management had led to some very poor decision-making. The community rehabilitation company (CRC) was not yet sufficiently established or effective. Some good work was done to help prisoners with housing needs but there were no comprehensive statistics on the number of men released without accommodation. Outcomes for prisoners were not sufficiently good against this healthy prison test.

### Key recommendations

All relevant departments and agencies should play a full part in strategic and risk management work, including relevant meetings.
**Not achieved**

All prisoners should have an up-to-date OASys assessment.
**Not achieved**

The CRC should ensure that all eligible prisoners receive an initial resettlement plan which is reviewed before their release.
**Not achieved**

### Recommendations

Visits procedures and facilities should provide a positive experience of efficient, welcoming and rehabilitative culture in the prison.
**Achieved**

The prison should investigate the reason for the low home detention curfew approval rate and make any necessary changes.
**Not achieved**

The prison should keep comprehensive transfer data so that it can monitor performance and demonstrate any systematic problems that it is experiencing with the national prison estate.
**No longer relevant**

Prisoners should be able to make written representations for re-categorisation reviews.
**Not achieved**

Staffing levels and referral procedures should ensure that all prisoners can access suitable interventions.
**Not achieved**

The needs of care leavers should be fully understood and appropriate interventions and support made available.
**Not achieved**

## Recommendations from the scrutiny visit

The following is a list of the recommendations made in the scrutiny visit report from 2020.

Managers should make sure that data are used effectively to identify concerns and take action which leads to tangible and demonstrable improvements in prisoner outcomes.
**Not achieved**

Managers should use proportionate means to deal with lowlevel transgressions by prisoners.
**Achieved**

All recommendations from death in custody reviews should be implemented swiftly. Managers should, in particular, address urgently the slow response to emergency cell bells and the inconsistent quality of ACCT processes.
**Not achieved**

Managers should make sure that all cells are kept in a good state of repair and provide decent living conditions. Problems reported by prisoners should be addressed promptly.
**Not achieved**

The evening meal should not be served before 5pm.
**Not achieved**

Prisoners with disabilities should not be held in Pentonville if they have no ready access to outdoor exercise areas and key provision, such as work and education.
**Not achieved**

All prisoners should be able to have a shower and outdoor exercise every day.
**Not achieved**

The prison should continue to work with community partners, with appropriate support from HMPPS, to ensure that no prisoners are released without settled accommodation.

**Not achieved**

# Appendix I About our inspections and reports

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

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

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

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

**Respect**
Prisoners are treated with respect for their human dignity.

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

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

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

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

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

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

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

Our assessments might result in 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 provides a summary of our inspection findings against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 5, 2017) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/). Section 7 summarises the areas of concern

from the inspection. Section 8 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

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

**Inspection team**

This inspection was carried out by:

| | |
|---|---|
| Martin Lomas | Deputy chief inspector |
| Hindpal Singh Bhui | Team leader |
| Liz Calderbank | Inspector |
| Ian Dickens | Inspector |
| Sumayyah Hassam | Inspector |
| Deri Hughes-Roberts | Inspector |
| Ali McGinley | Inspector |
| Chelsey Pattison | Inspector |
| Sara Pennington | Inspector |
| Nadia Syed | Inspector |
| Helen Downham | Researcher |
| Rahul Jalil | Researcher |
| Emma King | Researcher |
| Isabella Raucci | Researcher |
| Nisha Waller | Researcher |
| Tania Osborne | Lead health and social care inspector |
| Lynn Glassup | Health and social care inspector |
| Bev Grey | Care Quality Commission inspector |
| Lynda Brown | Ofsted inspector |
| Matt Hebditch | Ofsted inspector |
| Steve Lambert | Ofsted inspector |
| Shane Langthorne | Ofsted inspector |
| Saher Nijabat | 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.

**Cohorting**
To avoid gang and other conflicts, the prison kept prisoners in set cohorts when they attended activities requiring movement off their wing, which minimised the mixing of prisoners between wings.

**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.

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

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

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

**Recovery plan**
Recovery plans are published by HMPPS and aim to ensure consistency in decision-making by governors, by setting out the requirements that must be met for prisons to move from the most restricted regime to the least as they ease COVID-19 restrictions. (https://www.gov.uk/government/publications/covid-19-national-framework-for-prison-regimes-and-services)

**Secure social 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 call can be booked, users must upload valid ID.

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

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

# Appendix III  Care Quality Commission Requirement Notice

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

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

**Provider**

Practice Plus Group Health and Rehabilitation Services Limited.

**Location**

HMP Pentonville

**Location ID**

1-4067506624

**Regulated activities**

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

**Action we have told the provider to take**

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

**Regulation 12: Safe Care and Treatment 12 (1)(2.1,2.2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

To meet this regulation; care and treatment must be provided in a safe way for service users. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – assessing the risks to

the health and safety of service users of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks.

**How the regulation was not being met**

- Patient applications were not always collected and triaged on a timely basis and we identified a significant delay in referring a patient under the two-week wait cancer referral pathway.
- We found 197 applications which had not been collected for at least five days. Within the applications we identified some patients who required both urgent and routine appointments. Some prisoners told us that they put in several applications to see health care staff but that they received no response.
- Through a random review of patient records we identified one patient where there had been a significant delay in making a referral under the two-week wait cancer pathway.

To meet this regulation; providers must have a suitable system in place to ensure patients receive safe care and treatment and that avoidable harm or risk of harm is prevented.

# Appendix IV  Further resources

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

## Prison population profile

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

## Prisoner survey methodology and results

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

## Prison staff survey

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

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

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

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