Report on an unannounced inspection of

HMP Wayland

by HM Chief Inspector of Prisons

11–12 and 25–28 April 2022

Contents

Introduction

HMP Wayland is a category C training prison near Thetford in Norfolk that held 890 prisoners when we inspected in April this year. The remote location on an old RAF base on the edge of Thetford forest has made the recruitment of staff very difficult and at the time of the inspection there were not enough officers to run anything like a proper category C regime.

Standards of behaviour in the under-staffed prison had slipped and inspectors often saw prisoners breaking the rules without challenge or adequate supervision from officers, many of whom had only recently begun working in the jail. With experienced prisoners and inexperienced staff, there is a real risk that things could get much worse.

The new governor, who had taken over at the end of 2021, had begun to address some of the worst behaviour, sending some of the most troubled prisoners back to category B prisons and aiming to improve the support for newer officers. The staff team appreciated her visibility around the jail and her priorities were generally well understood. Much will need to be done to establish higher standards of behaviour from both prisoners and staff, some of whom we also saw vaping around the prison. To date, the focus had been on sanctions, but leaders will also need to find more positive ways to motivate prisoners to behave well.

Wayland seemed to suffer from the same post-COVID-19 inertia that has affected many of the category C prisons we have recently inspected. Workshops and classrooms were mostly empty, and prisoners were spending too much time locked in their cells. Education provision had restarted just days before our arrival although to their credit, teachers had been much more active during the lockdowns than in other jails. Inexplicable restrictions on the number of prisoners allowed into classrooms and workshops – despite prisoners being able to mix freely elsewhere, such as in the kitchens – will need to be lifted if the prison is to be able to provide education and training for more than just a lucky few.

During our inspection, leaders introduced a new regime designed to open the prison up and provide more purposeful activity, but the planning was rushed and communication had not been good enough, so that prisoners and staff did not know who was supposed to be where at what time.

The general condition of the site was poor. Cells in the older part of the jail were tired looking, many with windows that needed repair. In the newer wings, poor ventilation meant that in-cell showers had mould growing on the walls. Elsewhere, the kitchens were in an awful state and there was a gaping hole in the roof of the visits hall.

The recent designation of Wayland as a ‘black’ site for staff recruitment and retention means that it is able to pay staff more to work in the prison. We must hope that this begins to resolve the critical staffing situation, because without sufficient, high-quality officers, there is a real risk that standards of behaviour

may deteriorate further and the prison will continue to fail to live up to its category C designation.

Charlie Taylor
HM Chief Inspector of Prisons
June 2022

About HMP Wayland

Task of the prison/establishment
HMP Wayland is a category C training prison.

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 890
In-use certified normal capacity: 879
Operational capacity: 915

Population of the prison
- 940 new prisoners were received each year (around 78 per month).
- There were 97 foreign national prisoners.
- 47.5% of prisoners were from black and minority ethnic backgrounds.
- 30 prisoners were released into the community each month (average for last 12 months).
- 83 prisoners were receiving support for substance use.
- 130 prisoners were referred for a mental health assessment each month.

Prison status (public or private) and key providers
Public

Physical health provider: Practice Plus Group
Mental health provider: Practice Plus Group
Substance misuse treatment provider: Phoenix Futures
Prison education framework provider: PeoplePlus
Escort contractor: Serco

Prison group
Bedfordshire, Cambridgeshire and Norfolk

Brief history
HMP Wayland opened in 1985, with residential buildings added on four occasions. The last addition was in 2008, when 300 spaces were added across five new units. In 2020, F and H wings were demolished because of the fire risk of the buildings, reducing capacity by 80 places. A new segregation unit was under construction.

Short description of residential units
A: Normal location, high-risk cell sharing risk assessment (CSRA) – mostly single cells
B: Normal location, high-risk CSRA – mostly single cells
C: Normal location, high-risk CSRA – mostly single cells and constant supervision cell
D: Integrated drug treatment system and normal location, high-risk CSRA – mostly single cells
E: Wensum unit. North side: lifers and those serving an indeterminate sentence for public protection. South side: normal location – single cells and constant supervision cell

G: Rehabilitation of Addicted Prisoners trust (Phoenix); short duration drug programme; over-50s – single cells
J: Enhanced and category D unit
K: Normal location – double cells
L: Normal location – double cells
M: First night and induction
N: Normal location – double cells
PIU (formerly protective isolation unit): Single cells, enhanced
Reintegration unit (segregation).

Name of governor and date in post
Ali Barker, November 2021

Leadership changes since the last inspection
Paul Cawkwell, 2016 – June 2019
Sonia Walsh, June 2019 – May 2021
Steve Garvie (temporary governor), May 2021 – November 2021

Prison Group Director
Gary Monaghan

Independent Monitoring Board chair
Mike Gander

Date of last inspection
2017 – full inspection
2020 – scrutiny visit

Section 1 Summary of key findings

1.1 We last inspected HMP Wayland in 2017 and made 68 recommendations, four of which were about areas of key concern. The prison fully accepted 56 of the recommendations and partially (or subject to resources) accepted nine. It rejected three of the recommendations.

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

Progress on key concerns and recommendations

1.3 Our last inspection of HMP Wayland 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 follow up on recommendations about areas of key concern to help leaders to continue to drive improvement.

1.4 At our last full inspection, we made two recommendations about key concerns in the area of safety. At this inspection we found that both of those recommendations had not been achieved.

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

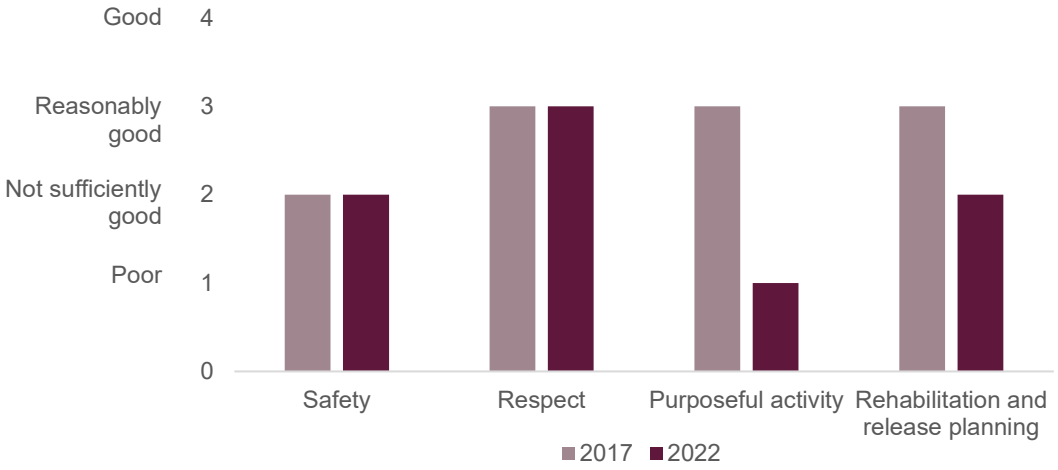
Outcomes for prisoners

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

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

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

Figure 1: HMP Wayland healthy prison outcomes 2017 and 2022



Safety

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

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

1.9 On arrival, many prisoners waited more than two hours before moving on from reception. Initial interviews were held privately but some were cursory. Prisoners could buy some basic items on arrival. Conditions in the first-night centre were satisfactory, and prisoners could contact their families. They did not reliably receive a thorough induction.

1.10 In our survey, 22% of respondents said they currently felt unsafe. Levels of violence against staff and prisoners remained high, but the number of serious incidents had decreased. All incidents were investigated, but not in sufficient depth, and there was little structured support for victims. A lot of low-level poor behaviour went unchallenged, such as prisoners being improperly dressed, vaping in communal areas, shouting and swearing. The violence reduction policy was not sufficiently focused on the current issues at HMP Wayland.

1.11 The number of adjudications had decreased considerably, but there was not always sufficient exploration of the reasons for poor behaviour. Quality assurance had restarted but was not yet effective.

1.12 The use of force had decreased since the previous inspection, but remained high. Incidents often reflected a lack of control and supervision, which meant that the use of force was not always necessary or proportionate, although oversight was beginning to improve.

1.13 Segregation staff had a good understanding of those in their care. The cells and facilities in the unit were not suitable, although they were kept

clean. Oversight and scrutiny of the use of segregation were weak, as was reintegration planning.

1.14 Physical security arrangements were generally proportionate, except for some strip-searching and handcuffing. Intelligence reports were processed and disseminated well, and targeted searches led to many finds.

1.15 The number of self-harm incidents was higher than at comparator prisons. Most Prisons and Probation Ombudsman recommendations made after investigation of deaths had been achieved, but there was no overarching strategy or action plan to reduce self-harm and support vulnerable people. The safety intervention meetings were not well attended and generated few actions. On the other hand, the enhanced support service provided good support for those with more acute needs. Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) were not well used, and several of those on assessment, care in custody and teamwork (ACCT) case management procedures for prisoners at risk of suicide or self-harm did not feel well supported. Although the basic processes were carried out appropriately, care planning was not used well and most case reviews were not multidisciplinary.

Respect

At the last inspection of Wayland, in 2020, we found that outcomes for prisoners were reasonably good against this healthy prison test.

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

1.16 Most prisoners said that staff treated them with respect, but far fewer said that any member of staff had recently asked how they were doing. Very few key worker sessions (see Glossary) took place. Staff did not always set a good example and some lacked professional confidence and personal authority with prisoners. In general, there was insufficient direct supervision of prisoners.

1.17 Most of the residential blocks were defective. Extensive improvement works were imminent. Minor repairs were dealt with and most cells were reasonably well-equipped. Most communal areas were clean, but litter had accumulated outside the older units. The newer accommodation had in-cell showers, but the lack of ventilation had already caused deterioration.

1.18 In our survey, 42% of prisoners said the food was good and the meals we saw were adequate, but those working in the kitchens were not sufficiently trained. The kitchens were in an unacceptably poor condition.

1.19 The prison council had met weekly through the pandemic and recordings of the meetings were made available in-cell. Applications

were submitted electronically and the system was working better than at the last inspection. Few prisoners felt that complaints were dealt with fairly and many of the responses we saw were not adequate.

1.20 Equality work was well managed, although with limited staffing. Ipswich and Suffolk Council for Racial Equality (ISCRE) provided useful support. The number of discrimination incident report forms submitted had increased. Quality assurance of these was robust, but responses were not always well written. The amount of consultation varied considerably between protected characteristics.

1.21 In our survey, the responses of prisoners from a black and minority ethnic background were generally similar to those of white prisoners. Staff training had begun, with prisoner input, to address an identified lack of cultural awareness.

1.22 The diversity and inclusion lead worked well with other departments to identify and meet the needs of prisoners with disabilities, but there was insufficient support for foreign nationals. Plans were being made to improve work with younger prisoners.

1.23 Corporate worship had only just resumed. Almost all prisoners had access to a chaplain of their faith and the chaplaincy provided good pastoral support.

1.24 Health services were well led and of good quality, but access to some was hindered by regime restrictions and a lack of officer escorts, contributing to some long waits. Health care staff had experienced some unacceptable behaviour by prisoners while administering and transporting medicines, causing serious risk. There was insufficient officer supervision of medicine queues.

1.25 The management of long-term conditions had improved. There were now nurse-led clinics with suitably trained staff, and evidence-based care plans. There was an up-to-date but insufficiently detailed agreement for social care between the prison and the local authority.

1.26 Mental health services provided comprehensive support, and one-to-one interventions were now delivered on time. The enhanced support service provided effective interventions for prisoners with especially challenging behaviour.

1.27 Phoenix Futures provided comprehensive psychosocial services and there was evidence-based clinical management of opiate substitution therapy.

1.28 Dental services were good, with notable clinical innovations such as triage on the wings. Work to improve airflow in the surgery had not been done, so aerosol-generating procedures (see Glossary) were unavailable.

Purposeful activity

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

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

1.29 A new regime, enabling some to go to work or education, started during the inspection, but reduced the minimum time out of cell for a minority of prisoners to one and a half hours a day. Many complained about the unpredictability of the regime. Most could have 30 minutes of outdoor exercise on three days a week and one hour on the other four.

1.30 The library had been closed since the start of the pandemic, but provided an efficient but limited remote service. Facilities in the two gyms were good, with at least two sessions a week available.

1.31 The prison was not sufficiently focused on the delivery of education and training. Prisoners' English and mathematics needs were not being met. Plans for the curriculum included reintroducing digital skills training. Prisoner pay rates were not a disincentive to participation in education.

1.32 Leaders had been too slow to improve access to good education and work, and especially vocational training. Prisoners were not allocated to activities according to career aspirations or needs. There were too few activity spaces and too many unemployed prisoners.

1.33 Prisoners did not have access to advice and guidance staff. They had, however, been able to use good in-cell learning packs. The relatively few who completed the packs found them useful, but too few could access face-to-face education. Education staff identified those with learning difficulties or disabilities promptly, sharing appropriate support plans with teachers, who used them well.

1.34 Too few instructors took existing skills and knowledge into account when planning activities. Most prisoners in work roles and workshops completed their work to an appropriate standard, but did not develop skills beyond the minimum requirements of the work. Those working in the wings or in the kitchens did not gain the essential qualifications.

1.35 Prisoners had positive attitudes in education and work and showed respect towards each other and staff. However, attendance was poor and too many were not punctual. There was no curriculum to promote personal development.

Rehabilitation and release planning

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

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

1.36 Prisoners could access two 60-minute visits each month. Arrangements for visits booking were inadequate, but visitors said that they had been well treated at the prison. The visits hall was shabby and the visitors' centre unwelcoming. There were two family development workers but no parenting courses, and the Storybook Dads programme (in which prisoners record stories for their children) was still paused.

1.37 Reducing reoffending work lacked direction. It was not supported by an overarching strategy, a clear action plan or effective use of data, and there was not a current needs analysis.

1.38 Most offender management unit (OMU) caseloads were too high, and the frequency and quality of offender manager contacts were too variable. The prison offender managers were not given sufficient training and support. Sentence plans were of uneven quality. Additional resources had been allocated to reduce a backlog, but at the time of the inspection 85 prisoners were without an offender assessment system (OASys) assessment.

1.39 Home detention curfew was reasonably well managed, although about half of the few who were eligible were released late. Use of release on temporary licence had resumed in 2022, but had been paused for security reasons.

1.40 Risk management processes, especially pre-release, were carried out systematically. Staff participated well in most aspects of multi-agency public protection arrangements (MAPPA). However, not all prisoners whose communications might have needed monitoring were identified on arrival, and monitoring was not sufficiently robust for those who were so identified.

1.41 Recategorisation reviews were carried out appropriately. Progressive transfers to category D establishments were slow; at the time of the inspection, 51 were waiting to move to open conditions.

1.42 Accredited interventions had continued to be offered throughout most of the pandemic, although waiting lists were long. Good in-cell programmes were in use, corresponding to the range of interventions that was available normally.

1.43 More prisoners than at the last inspection were released with suitable accommodation, but too many were still discharged with no fixed address. There was no resettlement worker, creating a major gap in service. Practical support on the day of release was minimal.

Key concerns and recommendations

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

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

1.46 Key concern: The governor had made a good start in setting some clear and positive priorities, of which many staff were aware. However, they were very broad and had not yet been turned into a practical programme of change that was clear to all. Although there was good analysis of data in many aspects of prison life, it was not yet leading to coherent programmes of action with clear success criteria.

Recommendation: The governor and senior managers should plan and communicate to all staff a clear programme for improvement in the establishment, based on data, driven through effective governance and engagement, and with clear criteria for measuring success.
(To the governor)

1.47 Key concern: Challenge, support and intervention plans (CSIPs) were not used widely or to full effect to manage perpetrators and victims of antisocial behaviour. There was little to motivate and encourage prisoners to improve their behaviour.

Recommendation: CSIPs should be used effectively to manage all those who are involved in, or victims of, violence and antisocial behaviour, and the incentives scheme should encourage prisoners to behave well.
(To the governor)

1.48 Key concern: As a result of the serious staff shortages, wings did not have a consistent staff group who knew the prisoners. The delivery of key work had fallen away, and only 20% of respondents to our survey said that in the previous week a member of staff had asked them how they were getting on. We saw many examples of staff not challenging low-level rule-breaking in communal areas, such as prisoners vaping, being improperly dressed, and shouting and swearing.

Recommendation: Prisoners should receive adequate supervision and support from staff on the wings, and live in an environment where expected standards of behaviour are known and upheld.
(To the governor)

1.49 Key concern: The violence reduction policy was mainly generic and not focused on the unique factors at the establishment that may have caused violence, such as the high prevalence of alcohol and drugs.

Recommendation: The violence reduction policy should be based on the specific issues at the establishment and should include an action plan for addressing the high levels of violence and its underlying causes, so that fewer fights and assaults take place.
(To the governor)

1.50 Key concern: While administering medication, health care staff had experienced some unacceptable behaviour from prisoners and were put at serious risk. The safety of health staff while transporting controlled drugs around the prison had sometimes been compromised by prison staff allowing prisoners along the route. There was insufficient officer support and management of medicine queues to promote patient confidentiality, lessen the opportunities for diversion and bullying, and support safe medicine administration.

Recommendation: Measures should be put in place urgently to protect health care staff from physical attacks while administering medication. Prison staff should supervise medicine administration and the transportation of medicines, including controlled drugs, effectively so as to preserve security, safety, and patient confidentiality.
(To the governor)

1.51 Key concern: The regime for prisoners had changed and time out of cell, including for exercise and structured association, had been reduced for many.

Recommendation: Access to purposeful activity should be expanded while maintaining sufficient time out of cell for all prisoners.
(To the governor)

Key concern: Leaders had not provided sufficient education, skills and work activities for all prisoners, and too many were not attending their allocated activities. Leaders had been too slow to reopen education classes, work and vocational training, and too many prisoners were unemployed. There was insufficient resource to meet the needs of the prison population in relation to English and mathematics.

Recommendation: Leaders should swiftly increase the availability of and attendance at activities, particularly in education and vocational training, so that prisoners are able to gain the skills and knowledge they need for employment when they are released, including improving essential English and mathematics skills.
(To the governor)

1.52 Key concern: Leaders and managers did not make sure that prisoners received useful, timely information, advice and guidance (IAG), and that they were allocated to activities that met their future employment goals and development needs.

Recommendation: Leaders should make sure that IAG staff engage appropriately with prisoners to establish their career goals and specific training needs. Staff should make sure that prisoners are allocated to activities that will help them to achieve their career goals.
(To the governor)

1.53 Key concern: Leaders and managers had not considered the quality of training that prisoners received in work roles and prison-led workshops. Too many prisoners were not challenged by their work and they were not able to achieve qualifications, or recognition of any skills and knowledge gained.

Recommendation: Leaders should identify and implement actions that will improve the quality of training and activities in prison-led work areas, so that prisoners are challenged to make progress. Prisoners should be able to achieve qualifications or have their new skills and knowledge recognised.
(To the governor)

1.54 Key concern: Leaders and managers had not made sure that education, training and work activities enabled personal development opportunities for prisoners. Teachers and instructors did not promote the importance of equality, inclusion or values of tolerance and respect, or help prisoners to explore their interests.

Recommendation: Leaders should make sure that the curriculum provided through education, skills and work helps prisoners to extend their knowledge and understanding beyond the subject being studied or their specific job role.
(To the governor)

1.55 Key concern: In our prisoner survey, only 18% said that staff encouraged them to keep in touch with family and friends. The visits offer for prisoners was still not good enough, and visits of no more than a hour were not adequate for many families who lived a long way away. Arrangements for booking visits were inadequate, and most of the visitors we spoke to said that they had experienced long delays trying to do this. The visitors' centre remained unwelcoming, with no facilities for refreshments, and the visits hall was shabby. There was no casework support for prisoners with family matters and there were no parenting courses.

Recommendation: The prison should make sure that prisoners have easy access to visits of a reasonable length as well as support to develop and maintain family ties.
(To the governor)

1.56 Key concern: The strategic management of resettlement had deteriorated considerably since the last inspection and lacked direction. The prison was not working towards an up-to-date, overarching reducing reoffending strategy and there was no coordinated oversight of data to monitor and improve outcomes for resettlement pathways. Work to reduce reoffending was undermined by the lack of a comprehensive needs analysis and action plan.

Recommendation: There should be a prison-wide reducing reoffending strategy and action plan, based on a comprehensive needs analysis, so that every prisoner is supported towards a law-abiding life on release.
(To the governor)

1.57 Key concern: Resettlement provision had deteriorated considerably since the last inspection. With no resettlement worker in post, support for release was not well coordinated. This gap in provision resulted in a disjointed and inconsistent resettlement service, with no plans or oversight of who needed support for release.

Recommendation: Staff should have a clear understanding of the resettlement needs of the population. Services delivered by resettlement partners should be coordinated effectively and quality assured so that the provision meets the need.
(To the governor)

Notable positive practice

1.58 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.

1.59 Inspectors found four examples of notable positive practice during this inspection.

1.60 The ‘one-stop shop’ clinic provided vaccinations and screening in one clinic, to try to increase uptake and reduce the non-attendance rates. (See paragraph 4.62.)

1.61 The excellent health reception packs given to all prisoners on arrival provided health promotion leaflets and information about health services at the establishment. (See paragraph 4.67.)

1.62 The mental health team offered a weekly self-referral clinic, where prisoners could discuss any mental health issues. (See paragraph 4.80.)

1.63 The use of digital in-cell communications with prisoners enabled the dental nurse to assess symptoms and select patients who needed to be seen. The nurse visited patients on the wings who could not be

brought to the health care centre to undertake triage if urgent. This enabled prompt access to dental care for the neediest and decreased the risk of dental problems turning into emergencies. (See paragraph 4.107.)

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 prison struggled with serious staffing problems, including a high resignation rate. Some very recent initiatives from HM Prison and Probation Service were likely to address this problem to an extent, through investment in staff and limited reductions in prisoner numbers.

2.3 The governor had made a good start in setting some clear and positive priorities, of which many staff were aware. However, they were very broad and had not yet been turned into a practical programme of change that was clear to all; leaders had not yet managed to instil a motivating vision or determination to create an excellent prison. (see key concern and recommendation 1.46).

2.4 The levels of violence and of self-harm were still relatively high, but the first three months of 2022 had shown some promising signs of a reduction. The incoming governor had understandably focused on reducing the worst of the violence and bullying. This emphasis on 'cutting crime' amounted to what was primarily a punitive approach to compliance, and this needed to be complemented with creative approaches to encouraging and incentivising positive behaviour and engagement.

2.5 Leaders had not been making sure that all staff were confident in their roles, although a training programme had recently started. Low-level rule breaking was too often overlooked (see key concern and recommendation 1.48). The balance of power on the residential units was not always clearly enough in favour of the staff. Not enough managers were visibly modelling positive and prosocial behaviour to staff and prisoners.

2.6 Leaders had not adequately planned, or communicated clearly to staff and prisoners, changes in the regime and, although much information had been issued recently, there was widespread confusion about what was expected.

2.7 Managers were giving an energetic lead, in some areas such as equality and security, although in others, it was too soon to see clear results. In the health care department there was good leadership which focused on quality, transparency, use of data and training for individual staff.

2.8 There was good analysis of data in many aspects of prison life, but it was not yet leading to coherent programmes of action with clear success criteria. Strategic meetings to drive improvement and delivery in key areas had only recently resumed. This included reducing reoffending, and oversight of the use of force (see key concern and recommendation 1.46).

2.9 Leaders had not prioritised education and training or made good use of the excellent resources available. Leadership of this area had lacked continuity. As a result of staff shortages, there had been very little education and training for the last two years and opportunities were increasing too slowly. Education leaders and managers understood accurately the strengths and weaknesses of the provision and had identified sensible actions for improvement.

2.10 Leaders were not sufficiently driving a coherent and strategic approach to working with every prisoner to reduce the risk of reoffending. The programmes team was well led and effective, but resettlement provision for those released had suffered through the loss of the specialist team in mid-2021, with the gaps only being filled slowly and partially.

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 The reception area was compact but generally tidy. The holding room contained some information and a television, but the area as a whole had limited and out-of-date facilities.

Holding room in reception

3.2 At the time of the inspection, there were no arrivals as one house block was being emptied for refurbishment (see also paragraph 4.5), so we could not observe the reception process. However, staff and prisoners told us that the usual procedure involved newly arrived prisoners being brought in one by one from the vans, given a rub-down search and offered an amnesty for illicit items before entering the reception area. There, they were all subject to a full search and use of the body scanner. Those who refused to go on the scanner were taken to the segregation unit, in line with the secreted items policy. Remaining prisoners waited in the van until the person ahead of them had

completed this process, which meant that they often waited in the van for a long time. In our survey, only 36% of respondents said that they spent less than two hours in reception, which worse than the average for comparable prisons.

3.3 There was a private space in reception for health care staff to conduct their assessments, and a further one for officers' initial interview. The quality of initial interviews varied; some were relatively brief and paper records lacked detail, especially for late arrivals, which meant that immediate risks and vulnerabilities might not have been identified or explored sufficiently. We were told that vans often arrived very late and sometimes health care staff did not get the opportunity to speak to prisoners on arrival (see also paragraph 4.66).

3.4 New prisoners could buy a small variety of basic items. In our survey, 76% of respondents said that they had had access to the shop during their early days at the prison, which was better than in similar prisons (55%).

3.5 Conditions in the first night centre were satisfactory, although some cells had insufficient furniture and prisoners told us that some had not received an in-cell laptop, which should have been issued to all of them. Cells on the unit contained showers, although ventilation was poor (see paragraph 4.11).

3.6 Leaders had taken steps to improve the timeliness of access to in-cell telephones for new prisoners, by switching on their PIN number on arrival. In our survey, fewer respondents than at similar prisons said that they had had problems with contacting family or getting telephone numbers during their early days at the prison.

3.7 Records of induction were poor; the prison gave each prisoner an 'induction passport' but many were not fully completed. In our survey, fewer respondents than elsewhere and at our last inspection said that they had received an induction, and many told us that they had not received an induction. Those we spoke to were particularly disappointed that, during induction, they had not met representatives from several key departments and agencies in the prison, although chaplaincy and education staff had come to see them on the wing.

3.8 The regime for those in their early days was poor, with only 30 minutes a day in the open air and no other time out of cell. The temporary exercise area in use during the inspection, a very small patch of grass, was inadequate. Some prisoners had experienced this poor regime beyond their post-arrival isolation period while waiting for a wing move.

Temporary exercise area

Recommendation

3.9 **All prisoners should receive a thorough and multidisciplinary induction, after their vulnerabilities and risks have been properly explored on arrival.**

Managing behaviour

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

Encouraging positive behaviour

3.10 In our survey, 22% of respondents said that they currently felt unsafe, which was similar to the last inspection.

3.11 The overall levels of violence against staff and prisoners were high, but the number of serious incidents had decreased. In the previous 12 months, there had been 137 assaults against prisoners and 92 against staff.

3.12 All violent incidents were investigated, but not in sufficient detail. The casework approach to supporting victims and managing perpetrators of violence through challenge, support and intervention plans (see Glossary) was not used to full effect (see key concern and recommendation 1.47). There was too much reliance on the incentives

scheme and adjudication processes to deal with perpetrators of violence or antisocial behaviour. There was little support for the victims of violence beyond a visit from a safer custody officer.

3.13 During the inspection, we saw low-level poor behaviour going unchallenged on many occasions – for example, prisoners being improperly dressed, vaping in communal areas, shouting and swearing. Some prisoners told us that they felt intimidated by this behaviour and wanted staff to do more to manage it (see also paragraph 4.1, and key concern and recommendation 1.48).

3.14 There was a violence reduction policy, but this was mainly generic and not focused on the unique factors at the establishment that might have caused violence, such as the high prevalence of alcohol and drugs (see key concern and recommendation 1.49).

3.15 In our survey, only 41% of respondents said that the incentives or rewards in the prison encouraged them to behave well, and only 37% that they had been treated fairly by the scheme. The prison lacked creativity in motivating and encouraging prisoners to reach the enhanced level of the scheme (see key concern and recommendation 1.47).

3.16 The basic level of the incentives scheme focused on punishment rather than interventions to improve behaviour. Behaviour improvement targets were too generic and not tailored to the individual. Despite reviews being undertaken, too many prisoners remained on the lowest level for 14 days, even when their behaviour improved.

Recommendation

3.17 **There should be formal support for victims of antisocial behaviour or violence.**

Adjudications

3.18 There had been 1,882 adjudications in the last 12 months, which was a considerable decrease since the previous inspection. Data showed that around 23% of adjudications were not proceeded with. In the sample we viewed, the awards were generally appropriate, but discussions with prisoners did not always explore the reasons behind their poor behaviour in sufficient detail. For example, some were often found brewing alcohol, but there was a lack of inquiry about the reasons behind this, such as being the victim of bullying. Serious offences were appropriately referred to the police for further investigation.

3.19 Quality assurance, which included a review of around 10 adjudications each month by the deputy governor, had recently restarted, but was not yet effective at improving practice. The segregation monitoring and review group meeting (SMARG) had also recently resumed and had begun to review a wide range of adjudications data, including the protected characteristics of those involved.

Use of force

3.20 There had been 418 incidents involving the use of force in the previous 12 months, which was a reduction since the previous inspection, but high in comparison with other prisons. Around 80% of incidents were spontaneous and they often reflected a lack of control and supervision by staff. In one of the body-worn video clips we saw, many frustrated prisoners were allowed to crowd into a staff office on the wing, which resulted in a use of force.

3.21 In other footage we viewed, the use of force was not always proportionate. Some incidents were poorly managed, and techniques not used appropriately. Additionally, body-worn video cameras were underused; there was no footage for 44% of all incidents. This made it difficult for leaders to identify issues and take action against poor practice consistently when required. Batons had been used in two incidents in the last 12 months. Investigations into the use of batons were not sufficiently detailed and did not provide assurance that their use was necessary or proportionate.

3.22 Following a long gap, oversight of the use of force by leaders was beginning to improve and had started to identify some of these issues. The deputy governor now chaired a weekly meeting and reviewed the video footage that was available, alongside corresponding staff statements. When footage showed poor practice, leaders took action to address this. In the previous 12 months, managers had commissioned eight investigations into apparently inappropriate use of force. The quarterly use of force committee identified trends over time, as well as considering the use of force among different groups of prisoners.

3.23 Special accommodation had been used twice in the previous 12 months, which was a reduction since the previous inspection. The average length of stay was around one day. Records we saw did not always show sufficient justification for the prisoner to remain in special accommodation; in one example, records stated that the prisoner was 'sitting down reading', strongly suggesting that special accommodation could have been ended earlier.

Segregation

3.24 The staff in the 'reintegration unit' had a good understanding of those in their care. Seven prisoners were segregated in the unit during the inspection, one of whom was being supported through the assessment, care in custody and teamwork (ACCT) case management process, and appropriate justification for his segregation was in place.

3.25 The unit was clean, but showers were in poor condition, with ingrained dirt. The cells were shabby, bare and without in-cell electricity. A new segregation unit was nearing completion.

3.26 Segregated prisoners had access to a portable radio in their cell and a hand-held games console if they were not on the basic level of the

incentives scheme. The exercise yard was spacious and contained gym equipment.

Exercise yard on segregation unit

3.27 The regime was basic, consisting of a telephone call, shower and time in the fresh air, with around 23 hours of lock-up each day. Prisoners were able to participate in in-cell work packing balloons, but none had taken this up during the inspection.

3.28 The average length of stay in the unit in the previous 12 months was 10.88 days. In the previous three months, 15 of the 50 people segregated were transferred to another establishment, four of them after recategorisation from C to B.

3.29 Oversight and scrutiny of the use of segregation were weak. The recently reintroduced SMARG (see paragraph 3.19) had begun to interrogate some data. However, the terms of reference of the group outlined a limited list of attendees which lacked multidisciplinary input. There had been some recent changes in the leadership and staffing of the unit, but there was not yet evidence of any creative interventions or partnership working to encourage positive behaviour or address underlying causes for segregation.

3.30 In the sample of paperwork we reviewed, the use of segregation was not always fully justified. Reviews often lacked detail and targets were too generic; there was no quality assurance which might have picked up these issues. Only one of the seven prisoners in the unit during the inspection had a care plan, and most did not have a substantial reintegration plan.

Recommendation

3.31 **Oversight and scrutiny of the use of segregation should be robust and contribute to improvements, including consistent reintegration planning.**

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.

3.32 Physical security arrangements were generally proportionate and aligned to risks. However, some elements of procedural security were disproportionate. Although the body scanner was used well for new arrivals, prisoners leaving Wayland and all those located in the segregation unit were indiscriminately strip-searched, and the use of restraints when escorting prisoners on appointments outside the prison was not always justified by an individual risk assessment. For example, a 69-year-old prisoner in a wheelchair who was unable to walk was handcuffed to an officer for attendance at hospital appointments, having been strip-searched before departure, which was undignified and unnecessary. A previous Prisons and Probation Ombudsman (PPO) recommendation had raised concerns about this practice.

3.33 Managers were aware of the prison's key threats, which were alcohol and the entry of drugs. Around 956 intelligence reports were submitted a month and reports were analysed, collated and disseminated well. Leaders had identified that the flow of intelligence from some areas was poor and security managers were trying to raise awareness of the process to improve this.

3.34 Many targeted searches led to illicit items being found. In the previous 12 months, searches had resulted in the recovery of alcohol on 456 occasions and drugs on 216, as well as 152 weapons and 95 mobile phones. The machine used to detect drugs coming in through prisoners' mail was used effectively.

3.35 In our survey, 41% and 38% of respondents said that it was easy to get illicit drugs and alcohol, respectively, at the prison, both of which were higher than at other similar prisons.

3.36 The national suspension of mandatory drug testing (MDT) during the pandemic meant that although drugs posed a clear threat at Wayland, leaders were not able to gather and understand key data on drug use, and that the MDT process as a deterrent to illicit substance misuse was undermined.

3.37 The monthly local tactical assessment was good and provided an overview of key security concerns from the previous month. However,

minutes from monthly security meetings did not demonstrate enough analysis of the available data, or always identify actions to make sure that issues raised by the data were addressed. For example, the suspension of MDT, and its impact, had not been discussed, despite drugs being identified as a key threat. Some actions rolled over from one month to the next without resolution. For example, minutes in September 2021 raised a concern about the lack of intelligence reports from one area in the prison. This remained an action in March 2022, without any evidence of clear plans to address this.

3.38 Links with the police were good and police intelligence officers worked well with the security team. There was inter-agency work to manage identified extremists. Work to tackle staff corruption was good.

Recommendations

3.39 **The strip-searching of prisoners, and their handcuffing on escort, should be based on a full risk assessment and be proportionate to the risks posed.**

3.40 **Mandatory drug testing should be reinstated.**

Safeguarding

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

Suicide and self-harm prevention

3.41 There had been two confirmed self-inflicted deaths since the last inspection and six confirmed deaths from natural causes. Most recommendations made by the PPO had been achieved, particularly those relating to health care (see also paragraph 4.53).

3.42 The number of self-harm incidents was higher than the average for category C prisons, and similar to that at the last inspection.

3.43 There was a safeguarding policy, but this was not specific to Wayland. There was no overarching strategy or action plan for reducing self-harm and suicide prevention. While some useful data were evaluated regularly, these analyses were not used effectively to work towards better outcomes.

3.44 The prison held monthly safety meetings and fortnightly safety intervention meetings (SIMs). The SIMs were not well attended, and documentation indicated that they generated few actions. However, the enhanced support service (ESS) provided good support for prisoners with a very high level of need (see paragraph 4.86). Prisoners receiving

this service to whom we spoke were positive about the support they received through the ESS.

3.45 Those who were identified as being at risk of self-harm or suicide were subject to the ACCT case management process. There were 14 prisoners on an ACCT during the inspection, and over the last six months the average length of time on these procedures was 13 days.

3.46 Several of the prisoners currently on an ACCT told us that they did not feel well supported. Although the basic processes were carried out appropriately, care planning was not used well to address underlying issues; for example, targets set in the care plan were not always meaningful for the prisoner in question. There were some gaps in entries from staff and supervisor checks. Quality assurance was carried out by the safer custody team, who provided individual feedback to relevant case managers. Case reviews were not multidisciplinary; although it was positive that a member of the health care or the mental health teams were present at these, in most cases they were not attended by a range of relevant stakeholders with key perspectives to contribute.

3.47 There were two constant watch cells. There had been 14 instances of constant watches in the previous six months, the longest period being 22 days. The use of anti-ligature clothing was not recorded routinely.

Constant watch cell

3.48 There was an enthusiastic team of Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners), but most of them had not been called out.. The scheme had recently been fully reintroduced following some curtailments during the COVID-19 pandemic and had not yet been embedded across the prison. Prison officers were not clear or consistent when describing the use of Listeners. The Listener suite was in a poor state of repair.

Listener suite

3.49 At the time of the inspection, 10 prisoners were self-isolating. The management of these individuals was inadequate. Although staff made sure that they had access to a shower a few times a week, there was not yet any wider support to help them engage with the regime, address the underlying reasons for their decision to self-isolate and help them work towards reintegration.

Recommendation

3.50 **Prisoners at risk of self-harm or suicide should be given good support through the assessment, care in custody and teamwork (ACCT) process, and those self-isolating should be supported through discussing the reasons and working towards reintegration.**

Protection of adults at risk (see Glossary)

3.51 The prison had not established links with the local safeguarding adults board and the safer custody team had not made referrals to the local authority. Leaders told us that there had been some historic examples of working with the community to support individual prisoners, but there was no overarching framework or process for this.

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 As a result of the serious staff shortages, there was no longer a consistent staff group on each wing who knew the prisoners in their care. Managers told us that the high turnover of staff and the reliance on those temporarily posted from other prisons made it more difficult to achieve consistency in staff behaviour. We saw some positive interactions between staff and prisoners, but too often we observed staff failing to challenge low-level rule breaking in communal areas (see paragraph 3.13), and some officers lacked professional confidence and personal authority with prisoners. Staff did not always model the expected behaviour; for example, some were vaping as they walked between buildings. The layout of the older units did not offer good lines of sight, and groups of prisoners often congregated with no staff presence; closed-circuit television did not provide an adequate substitute (see key concern and recommendation 1.48).

4.2 In our survey, 70% of respondents said that staff treated them with respect. Only 20% however, said that any staff member had recently asked how they were doing, which was much lower than at the last inspection (36%) and at similar prisons (30%). Managers told us that because of staff shortages, the key worker scheme (see Glossary) had almost stopped functioning. Data from the electronic prison records indicated that 12% of target key work sessions had been completed in March 2022, but many entries simply said that the planned session had not taken place.

4.3 Prisoner representatives had been appointed for each wing. These were called 'information, advice and guidance representatives', although they had not received training from the education providers to perform this task and most described their role as primarily to attend the weekly prison council meetings (see also paragraph 5.11).

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 The prison occupied a large site, with plenty of space in the open air for exercise. The external areas were generally well-maintained, although litter had been thrown from the windows in A to D wings, which was not cleared during the inspection.

Litter outside A wing

4.5 Most of the living accommodation comprised two groups of buildings, one group older than the other. Even the newer buildings looked shabby and were in need of substantial repair and refurbishment. An extensive programme of works to improve living conditions was due to start and G wing had been closed temporarily to allow this. The plans included the replacement of windows and refurbishment of showers across the establishment, a wing at a time.

4.6 The older units had flat roofs and in some areas they had been leaking for a long time, leading to staining on the ceilings and the floors beneath. Leaks into and from the laundry rooms on the first floor had also seeped through and into the serveries below. Some water overflows ran directly down the outside walls of the ground-floor cells and prisoners in these cells showed us moss growing on the windows.

4.7 There were fewer single cells used to accommodate two prisoners on the older units than at the previous inspection, although there was still no screening of the toilet in shared cells and some prisoners had resorted to hanging up a sheet. Most cells were adequately furnished, although much of the furniture had been repeatedly repaired and now needed replacement. The prison had formed a works party of four prisoners, supervised by a member of the facilities management team.

They (one of whom was a trained plumber) were able to respond quickly to minor day-to-day repairs.

Unscreened toilet in a double cell on D wing

4.8 The older units had communal showers which were stained, grubby and in need of a deep clean. Prisoners told us that the hot water often ran out when many had a shower in quick succession.

4.9 All wings had laundry facilities, although at least one of the driers was out of action on each, and laundry workers said that this had been the case for many weeks. Managers told us that the electrical supply could not cope with industrial driers, so domestic appliances were used, but these often broke down through high usage. They were not covered for repair by the facilities contract.

4.10 All cells on E wing were single occupancy and most were in reasonably good condition. Both the two spurs on the wing had a designated self-catering room, which included a fridge-freezer, microwave ovens, toasters and mini-ovens with hobs. However, there were no sinks in these rooms and no pots or pans had been issued.

Typical cell on E wing

4.11 Cells on the enhanced wings (PIU, previously the protective isolation unit, and J wing) were single occupancy, while those on the remainder of the newer units were doubles. All of these had in-cell showers, but there were no extractor fans, leading to damp, mould and mildew, made worse in some cells as the windows were stuck closed. Some of the floors in the newer cells were also peeling because of damp and water leaks.

Single cell on J wing

4.12 Communal areas on the wings were generally clean, although many of the cleaning stores had missing or damaged items, such as mop heads with no handles. All wings had association areas with equipment such as pool, snooker and table tennis tables.

4.13 Some prisoners told us that staff sometimes took too long to respond to cell call bells. We saw these generally being answered promptly, and this was supported by data from the monitoring system in place on some units. However, until the inspection, managers had not been aware that they could obtain these data.

Residential services

4.14 In our survey, 42% of prisoners said that the food at the prison was good, and the meals we saw were adequate, although only 37% said that they got enough to eat at mealtimes. There was no longer a regular food consultation meeting, but catering issues were sometimes raised at the weekly prison council and electronic applications could be sent directly to the catering manager.

4.15 There were separate kitchens for the old and new sites, both of which were in an unacceptably poor condition: the floors were damaged, which prevented effective cleaning, and a recent visit by the environmental health officer had led to a follow-up visit because of concerns and there was a further one due to check outstanding actions.

4.16 Wing serveries were not always cleaned after use, and on more than one occasion we found waste food left standing during the day, dirty

servery equipment from the previous evening, and floors that had not been swept and mopped.

Dirty servery floor on D wing

4.17 Prisoners working in the kitchens had not completed any food hygiene accreditation, and those working on wing serveries had not received any structured food hygiene training. During the inspection, servery workers often did not wear the correct personal protective equipment. We also saw uniformed staff helping on the servery without wearing protective clothing. Some records of food temperatures were taken on the serveries, but they were incomplete.

4.18 A DHL workshop on-site provided the prison shop service to a number of establishments, which meant that staff were usually available to rectify any issues with individual shop orders. New prisoners could receive an advance on their wages to make purchases from a limited range of goods to cover the period before they could make a full shop order.

Recommendation

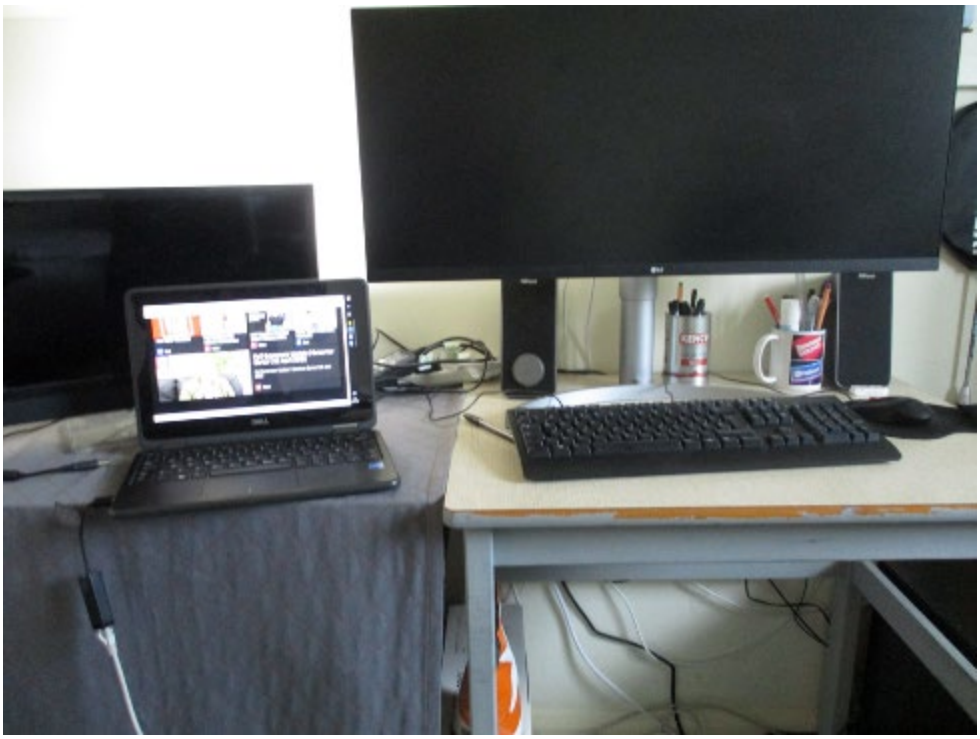
4.19 **Food should be prepared and served in safe and hygienic conditions.**

Prisoner consultation, applications and redress

4.20 The prison council had met weekly through the pandemic and this had led to some changes, such as prisoners being allowed to wear their own clothing during visits. Live recordings of the full meetings, together with a summary of the main issues and decisions made, were posted

on the prison's intranet, which prisoners could access via their in-cell laptop computers.

4.21 The digital hub was a useful source of information sharing for prisoners, and included a wider range of content, such as articles about prison life. A prisoner with relevant experience was employed as the production lead and had been provided with the necessary equipment to design and build the content. Most prisoners who had a laptop said that it was positive, with a few saying that it was the best thing about Wayland. However, we spoke to some prisoners who had not had a working laptop for several months and the prison did not have accurate data on who was without one.



Information technology equipment available to the digital hub production lead

4.22 Prisoners could submit applications via their laptop computer or by using the on-wing electronic kiosks. In our survey, far more respondents than at the last inspection said that applications were dealt with quickly (49% versus 25%). The prison monitored overdue responses daily, but had not yet started to analyse the applications data over time to identify trends and areas for improvement.

4.23 In the previous 12 months, the number of complaints per 1,000 prisoners had been increasing slightly and at the time of the inspection was above the average for similar prisons. In our survey, only 38% said that complaints were dealt with fairly, and only one in five that they were responded to quickly.

4.24 Many of the responses we reviewed were too brief and did not deal with all the issues raised, and some complaints had been closed before all the actions relevant to the investigation had been completed. There was a regular quality assurance process, but there was no evidence

that this was used to improve responses and there was no independent scrutiny of these.

4.25 The analysis of complaints data was good, including more information about protected characteristics than we generally see. This was presented at the monthly senior leadership team meeting, but there was no evidence that this led to any action to address long-standing areas of complaint, such as access to stored property.

4.26 The library had a good stock of legal textbooks and the librarian had helped some prisoners with legal issues by accessing other material online and providing photocopies.

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

4.27 The oversight of equality and diversity work was generally good, although dedicated staffing was limited, consisting solely of the diversity and inclusion (D&I) lead, who worked four days a week. Positively, she was a member of the senior leadership team.

4.28 There was a good D&I policy, which was being updated. The action plan was reviewed and updated regularly.

4.29 Well-attended D&I meetings, chaired by the deputy governor, were scheduled to take place every month, although the last two had been cancelled. Comprehensive equality data were presented to the meeting, but disproportionalities were not always explored or addressed adequately.

4.30 The prison had entered into a service level agreement with the Ipswich and Suffolk Council for Racial Equality (ISCRE), which provided valuable support to equality work in several areas.

4.31 Prisoners submitted an average of eight discrimination incident report forms (DIRFs) a month, an increase since the previous inspection. These were investigated and responded to by managers of the areas in which the allegations were made. ISCRE provided quality assurance, and responses were also reviewed by the D&I lead and the deputy governor. DIRFs were generally investigated appropriately, but responses were sometimes abrupt and lacking in courtesy. This had been picked up in the quality assurance process and the prison was planning to provide guidance to staff to address the issues.

4.32 There were prisoner D&I representatives for most residential units. Some of them attended the monthly D&I meeting and they also attended coordination meetings led by the D&I lead. ISCRE provided support to carry out their role. Some D&I representatives were active in their role and provided useful assistance to prisoners, while others were not fully clear about what was expected of them.

Protected characteristics

4.33 Senior managers acted as champions for specific protected characteristics, and most were involved in consultations with prisoners and the planning of celebratory events. The quantity and quality of consultations varied considerably between protected characteristics and many were not focused on identifying needs. We found examples where concrete points for action were either not identified or not taken forward.

4.34 About 47% of the prison population was from a black and minority ethnic background. In our survey, most of their responses were similar to those of white prisoners. However, only 7% said that a staff member had asked them how they were getting on in the previous week, which was far less than the 27% response from white prisoners. Through consultation, the prison had recently identified that many of these prisoners felt that many staff were not familiar with other cultures and therefore did not always know how to work with them. As a result, the prison had designed a cultural awareness programme for frontline staff. One session, jointly facilitated by ISCRE and prisoner representatives, had taken place and there were plans to expand this programme.

4.35 Around 30 prisoners had disclosed that they were from the Gypsy, Roma and Traveller communities. A recent consultation with them had highlighted a range of issues, including a perception that these prisoners did not always disclose their background because of concerns that it would affect their progression. This had not been identified for further exploration.

4.36 Over 10% of prisoners were foreign nationals, but little was being done for them. With the exception of the health care department, the prison did not use professional telephone interpreting services extensively. At the time of the inspection, only one prisoner was being held under immigration powers and his specific needs were being addressed.

4.37 Prisoners with disabilities were mainly identified via their records from other establishment or self-declaration on arrival. The prison had recognised that this led to under-reporting, particularly for those with hidden disabilities, and there were ongoing efforts across functions to make sure that others with disabilities were identified. In our survey, more prisoners with disabilities than others said that they felt unsafe and/or had experienced bullying. The prison was in the process of appointing a neurodiversity manager.

4.38 The D&I lead worked well with colleagues to meet the needs of prisoners with disabilities. There were local plans for those with support

needs that did not meet the threshold for a social care package (see Glossary). A peer support system had been introduced for prisoners to support others with non-intimate care, but at the time of the inspection there was only one such peer support orderly.

4.39 Personal emergency evacuation plans were in place for prisoners who needed them, but not all wings had readily available documentation indicating the support needed in the event of an evacuation.

4.40 There were no specific wings for older prisoners and they were dispersed throughout the prison. Support for them was limited, although retired prisoners had more time out of cell, and a consultation had identified that the clothing available to buy through catalogues did not meet their needs, so the options had been expanded.

4.41 Data indicated that young prisoners were disproportionately involved in violent incidents, and in our survey more prisoners under 25 than over said that they were subject to physical restraint and segregation. The prison had recently identified that it needed to enhance its work with these prisoners and was launching a young adults strategy.

4.42 Few prisoners disclosed that they were gay or bisexual. The prison considered that it was likely that there was under-reporting by such prisoners, which it attributed to concerns about negative implications if their sexuality became known by others. However, it had done little to explore this and there had been no work with gay and bisexual prisoners to address their needs. Celebratory events had been organised during Pride month.

Recommendation

4.43 **The prison should explore the reasons why prisoners with disabilities feel unsafe and/or experience bullying, and address the issues that are identified.**

Faith and religion

4.44 The large chapel and multi-faith room had been closed for corporate worship for most of the previous two years and had only just reopened. As a result of the ongoing restrictions, the numbers allowed to worship together remained limited, so Christian and Muslim prisoners could only attend their respective services once every three weeks. Members of other faiths, being fewer, were able to meet more regularly.

4.45 There were chaplains covering most religions either working at the prison or coming in on a contract or sessional basis and almost all prisoners had access to a chaplain of their faith.

4.46 The chaplaincy had provided good pastoral support throughout the pandemic. Chaplains regularly visited prisoners on assessment, care in custody and teamwork (ACCT) case management and attended ACCT reviews. However, they had limited involvement in resettlement.

Recommendation

4.47 **Prisoners should receive weekly corporate worship.**

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.

4.48 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC found there were no breaches of the relevant regulations.

Strategy, clinical governance and partnerships

4.49 Practice Plus Group (PPG) had provided health services since April 2019. NHS England and NHS Improvement (NHSE&I) also commissioned Phoenix Futures directly to provide psychosocial substance misuse services, and Community Dental Services CIC (CDS) as the dental provider.

4.50 Health services were well led and partnership working between health care teams and the wider prison had improved since the last inspection. Partnership working had been further strengthened to manage the serious COVID-19 outbreaks that the prison had experienced, and prisoners were provided with appropriate screening and vaccination.

4.51 Local delivery board meetings were yet to restart, although the partnership board had recently begun running again after a long gap. Commissioners had continued with regular contract review meetings throughout the pandemic. There was no recent health and social care needs assessment, but one was scheduled for the current financial year.

4.52 The health care building needed some structural repairs; two clinical rooms were out of action as a result of this and the pharmacy had a leaky roof. NHSE&I had supported the health care team in raising these issues with HM Prison and Probation Service (HMPPS), but work had only just started on creating a new pharmacy. The clinic rooms and waiting areas were clean, and regular infection prevention and control audits were completed.

4.53 An effective clinical governance framework focused on delivering and improving patient care. This included regular audits, quality assurance meetings and a patient safety incident review group, which provided thorough scrutiny of clinical incidents. Good progress had been made in addressing the health care recommendations from the Prisons and

Probation Ombudsman death in custody reports (see also paragraph 3.41).

4.54 As a result of staff vacancies within the pharmacy team, some services were stretched, but the health care teams had a good skill mix and were conscientious and professional. However, while administering medication, health care staff had experienced some unacceptable behaviour from prisoners and were put at serious risk (see paragraph 4.103 and key concern and recommendation 1.50).

4.55 During the height of the pandemic, there had been some gaps in clinical and managerial supervision, but this was now back on track and staff felt supported by the management team. Compliance with mandatory training was reasonable and professional development was encouraged.

4.56 Complex patients were reviewed regularly through a strong multidisciplinary approach. Daily handovers, well attended by representatives of all services, provided a forum for sharing pertinent patient information and any service updates.

4.57 Emergency equipment was well maintained, with regular checks, and contained all appropriate items to attend medical emergencies. Most staff had undertaken immediate life support, with further training booked.

4.58 Patients were consulted through a variety of methods, including the prison council and the health care representatives meeting, both of which influenced service delivery.

4.59 There was an established system to address patient complaints face to face. However, the system had caused unnecessary delays to responses, and in some cases complaints were closed with no investigation taking place. When we raised this during the inspection, it was addressed immediately. A new process and an assurance framework were implemented to make sure that all complaints were investigated and that the timeliness of responses was maintained.

Promoting health and well-being

4.60 PPG had a structured programme of health promotion activity linked to national campaigns, with relevant information displayed across the prison, although not enough was available in a range of languages. Good use was made of professional telephone interpreting services for health care appointments for patients for whom English was not their first language.

4.61 The main health promotion focus had been on managing COVID-19 and the promotion of the national vaccination programme. Uptake rates for COVID-19 vaccinations, including the spring booster, were good and achieved by a conscientious team. A helpful monthly health promotion newsletter was produced for prisoners, including information about COVID-19.

4.62 PPG had established a 'one-stop shop' clinic, where the primary care team offered all vaccinations, blood-borne virus testing and sexual health screening, which helped to increase the uptake and reduce non-attendance rates.

4.63 A range of age-appropriate national prevention screening programmes, such as for bowel cancer and abdominal aortic aneurysm, was available.

4.64 A hepatitis specialist nurse attended regularly, providing liver scans, and support and treatment for prisoners with hepatitis C.

4.65 The team provided a range of health promotion support, including weight management, blood pressure monitoring and NHS health checks. Barrier protection was available and advertised.

Primary care and inpatient services

4.66 Prisoners received a comprehensive health screening by a registered nurse in reception, including COVID-19 testing, and appropriate referrals were made. However, it was not a 24-hour service and there had been one or two new prisoners each month who had not received a health screening as they arrived after the health care team had left for the day or the team was not informed of their arrival by the prison (see paragraph 3.3). These prisoners were seen by health care staff on the following day. A secondary health screen was completed within the seven-day National Institute for Health and Care Excellence guidelines.

4.67 An impressive health reception pack was offered to new arrivals, with pertinent health promotion leaflets and information about health services at the establishment.

4.68 There was a suitable range of primary care and allied health professional support, but access to most services within the health care centre, including visiting X-ray, ultrasound and dental services, was hindered by regime restrictions and a lack of officer escorts. This contributed to long waiting times to see the podiatrist and physiotherapist. Prisoners expressed frustration when they were not escorted to the health care department by officers or informed of their appointments. The reasons for non-attendance were followed up. These appointments were rescheduled, which extended waiting times for patients and wasted clinical time. Additional sessions were organised to reduce the backlog.

4.69 Patients were able to see a GP or the advanced nurse practitioner for a routine appointment within two weeks and urgent referrals were prioritised appropriately.

4.70 The management of long-term conditions had improved since the last inspection. There were now nurse-led clinics with staff who had additional training. Care plans were evidence based and individualised, and the care documented was thorough.

4.71 There was effective administrative and clinical oversight of external hospital appointments, with 20 slots available weekly for external officer escorts. Some routine appointments had been cancelled by the hospital and also because of the lack of escort staff, but two-week urgent appointments were met.

4.72 Health care staff saw prisoners before release and medication was supplied as required. Condoms were available and a summary of care was sent to the GP.

Recommendation

4.73 **Patients should be able to access all health services promptly, to improve attendance and reduce waiting times.**

Social care

4.74 The prison had well-established links with Norfolk County Council. This was supported by a memorandum of understanding, but this needed reviewing to make sure that the social care provider, currently PPG, was included and that all appropriate information was encompassed.

4.75 No prisoners were currently receiving a social care package (see Glossary). However, a dedicated occupational therapist made sure that a range of specialist equipment was provided to help promote prisoners' independence and enable them to receive safe care and treatment.

4.76 There was a clear referral pathway and prisoners were able to self-refer.

Mental health care

4.77 Mental health services provided a comprehensive range of support to patients with mild-to-moderate and more complex needs, and one-to-one interventions were now delivered in a timely manner.

4.78 PPG provided a mental health service that supported patients seven days a week. The team consisted of a mental health lead, two registered mental health nurses, four support workers and an occupational therapist. Practitioners offered community-equivalent interventions, such as cognitive behavioural therapy, EMDR (see Glossary) and solution-focused therapy. There was access to learning disabilities-trained staff, who supported patients with neurodevelopmental needs.

4.79 There was a vacancy for a psychiatrist, but the regular agency psychiatrist was working 20 hours a week to cover this position. The psychiatrist carried out regular prescribing reviews. Two staff within the mental health team were due to complete physical health check training, so that they could carry out prisoners' annual checks, which were currently being provided by the primary care team.

4.80 All urgent referrals were screened appropriately and were seen within 24 hours. Routine referrals were seen within five days. Staff and patients could access a duty worker using the online application system. The weekly self-referral clinic, whereby prisoners could book an appointment to discuss mental health issues, was a good initiative.

4.81 At the time of the inspection, the team was delivering one-to-one interventions to 90 prisoners. Records demonstrated that patients had person-centred care plans, regularly reviewed risk assessments and comprehensive progress notes.

4.82 There were 13 prisoners on the care programme approach and they were receiving good support for enduring mental illness. Multidisciplinary reviews were organised, attended by the patient, psychiatrist, community mental health workers and key staff.

4.83 The team attended all initial ACCT reviews and subsequent reviews for patients on their caseload.

4.84 There had been six patients transferred under the Mental Health Act to mental health units between September 2021 and the end of March 2022. All but one had waited from five to over 20 weeks, which was longer than the transfer guideline of 28 days.

4.85 Norfolk and Suffolk NHS Foundation Trust (NSFT) was separately commissioned to deliver an improving access to psychological therapies (IAPT) service for prisoners with low-level mental health needs. The chaplaincy offered a counselling service.

4.86 NSFT provided the clinical input to the enhanced support service (ESS), which was part of the offender personality disorder pathway. The team accepted referrals from the offender management unit (OMU), prison staff and PPG's mental health team. ESS provided psychologically informed interventions to reduce risk levels and enable individual prisoners with challenging behaviour to engage more positively. The input was valued by those participating in the service.

4.87 Staff liaised effectively with community teams to make sure that patients had a discharge plan and were aware of how to seek continued support and medication, if needed, on release.

4.88 Since the last inspection, the mental health team had not been able to provide mental health awareness training for prison staff.

Recommendation

4.89 **The transfer of patients to hospital under the Mental Health Act should occur within agreed Department of Health timescales**. (Repeated recommendation 2.92)

Substance misuse treatment

4.90 Phoenix Futures ('Phoenix') provided drug and alcohol treatment services, which were well led and much improved since the last

inspection. There were now sufficient resources to offer comprehensive psychosocial treatments, including work with families. In our survey, 40% of respondents (against a comparator of 28%) said that the quality of the service from substance misuse workers was good.

4.91 The prison drugs strategy included suitable demand-reduction and treatment components, but it was not supported by an action plan. Dedicated wings were available for prisoners in clinical treatment or in recovery. There were group and individual meeting rooms on D and E wings, and it was hoped that E wing could be further developed to accommodate independent substance-free living. Phoenix staff supported prison meetings, such as security and safer custody, to coordinate care.

4.92 All new arrivals were seen by a practitioner within 72 hours and told how to get help with substance use. The referral system was open, and new cases were allocated promptly to practitioners for assessment. There were usually an average of 280 prisoners at a time in receipt of support and those we met valued the service.

4.93 In-cell and workbook materials were relevant and purpose-designed in-house. Motivational and educational one-to-one and group work was delivered according to need. Group work had restarted between COVID-19 outbreaks in September 2021.

4.94 Individual prisoner records contained recovery plans based on their needs and informative progress notes, but were paper based, which was inefficient. Work had begun to enable Phoenix to use SystmOne (the electronic clinical record), which would increase the efficiency of shared care.

4.95 There were 80 prisoners on opiate substitution therapy (OST) at the time of the inspection, prescribed and administered by PPG clinicians with suitable competencies. About 25% of them were on reducing regimes, which was appropriate. Clinical management of OST was in accordance with national guidelines, and Phoenix practitioners joined the required clinical reviews.

4.96 We observed OST administration on D wing, and this was technically good. However, supervision of the area by officers was problematic because of the room's location at the juncture of a wing entrance and prison main thoroughfare. Security had been compromised on a few occasions, including one recent major breach, leaving health care staff shaken (see paragraph 4.103, and key concern and recommendation 1.50). Patients waiting for OST expressed frustration at the unreliability of the start time of administration.

4.97 Two paid peer recovery workers had continued to work throughout the pandemic, supported by up to seven volunteer peer workers. Vital mutual aid provided by weekly Alcoholics Anonymous meetings had restarted since September 2021, and there were arrangements to reintroduce Narcotics Anonymous meetings shortly after the inspection, which would benefit many prisoners in recovery or abstinence.

4.98 Working relationships with community drug teams were effective. Pre-release plans were individualised and coordinated with the OMU. Harm minimisation advice was given routinely, and naloxone (to reverse the effects of opiate overdose) training and supplies were provided to take home, as clinically indicated.

Medicines optimisation and pharmacy services

4.99 Individually labelled medicines were dispensed by a registered pharmacy and delivered to the prison. We observed some delays between medicines being ordered from the pharmacy and arriving at the prison. This appeared to be mainly an issue with the carrier, but it resulted in prisoners not being able to collect their in-possession medication and therefore an increase in supervised medication being issued from stock. When the delivery arrived, the pharmacy team was not always notified by gate staff.

4.100 Stock check arrangements were recorded clearly, with medicines stored appropriately in the main pharmacy unit and wing treatment rooms. Medicines were moved around the prison by two technicians with radios. Clearance was requested beforehand to make sure that medicines, including controlled drugs, were not transported during prisoner movement times. This often resulted in long delays, and we were told that officers sometimes allowed prisoners along the route during transportation, which posed a risk (see key concern and recommendation 1.50).

4.101 A contemporary in-possession policy took account of both the prisoner and the medication. The risk assessment was carried out as part of the reception process. About 50% of patients received medication under supervision and 50% in-possession. Prisoners were able to request simple medicines, such as ibuprofen and paracetamol, without seeing a doctor. There were no pharmacy-led clinics.

4.102 Medicines were administered by trained pharmacy technicians and nurses each day on the wings. There was a shortage of pharmacy staff, with only four technicians out of eight substantive posts, which resulted in pressure on the pharmacy team. As a result of the regime, there were often delays in prisoners receiving their medication and we observed a morning administration round finishing at 11am.

4.103 While some administration queues had a small amount of officer support, this was not sufficient to promote patient confidentiality, prevent bullying and diversion, and support safe medicine administration. There had been a recent serious incident which had compromised the security of a treatment room and the safety of a nurse. The location and access to this room and the treatment room on D wing meant that there were often large groups of prisoners crowding around medication areas, with insufficient supervision. Gates on treatment rooms did not have Perspex screens and this had resulted in staff being kicked, grabbed and spat on (see key concern and recommendation 1.50).

Dental services and oral health

4.104 CDS had good management oversight, governance and reporting systems.

4.105 The dental nurse was on-site daily from Monday to Friday, and a dentist for half of the week. Unusually, the dental nurse attended daily health team meetings, to coordinate care and service delivery.

4.106 The dental surgery was equipped and maintained to community NHS standards, with separate decontamination facilities. The prison was waiting for instruction from HMPPS to start work on improving airflow to enable safe aerosol-generating procedures (AGPs; see Glossary) to be carried out, without which treatment options were limited.

4.107 As a result of innovation in daily triage, prisoners unable to attend the surgery were called by the nurse using in-cell communications, with triage undertaken on the wings if urgent. This enabled prompt access to dental care for the neediest and decreased the risk of dental problems turning into emergencies. Prisoners could be seen by the dentist within five days for urgent treatment and within four to six weeks for a non-urgent consultation. Up to 50% of prisoners failed to arrive for their appointments, mostly because of prison regime and staffing issues, which reduced efficiency.

4.108 The full range of NHS treatments, except for AGPs, was available. Patients had access to appropriate pain relief and antibiotics when needed. The dental nurse ran weekly triage clinics and delivered oral health promotion. Clinical record-keeping on SystmOne was good, and prisoners we spoke to said that they appreciated their dental care.

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 In our survey, 19% of respondents said that they spent less than two hours outside their cells on a weekday (against 50% in comparator prisons) and 27% on weekend days (against the 70% comparator). The prison was running a 'split regime', whereby prisoners on most wings would only be unlocked either in the morning or the afternoon. At the start of the inspection, the published regime for most prisoners – apart from those on an enhanced wing or undertaking essential work – provided three hours and 15 minutes out of cell per day. This consisted of an hour each for exercise and association, with the remaining time for domestic tasks. A similar regime was in place at weekends. We found that, in practice, because of regime slippage, prisoners often had less time out of cell than this, but they usually had at least two and half hours unlocked each day (see key concern and recommendation 1.51).

5.2 During the inspection, access to part-time education training and work was introduced for three days each week. On those days, prisoners in education or training were expected to be out of their cells for three hours and 45 minutes, while those refusing work or on the basic level of the incentives scheme were due to be out their cell for only one and a half hours. It was intended that those who were sick, retired or without a work allocation would be unlocked for two and a half hours a day. Exercise for all prisoners was reduced to 30 minutes on these 'activity' days, while only those unable to work had a reduced amount (45 minutes) of structured association. The regime on the four other days of the week continued as before (see key concern and recommendation 1.51).

5.3 As this change took place in the latter part of the inspection, it was not possible to judge how it was going to work in practice, although we observed a lot of confusion among staff and prisoners, and frustration among the latter about the perceived unpredictability of the regime and reductions in exercise and association (see key concern and recommendation 1.51).

5.4 The library had been closed since the start of the pandemic. With the reopening of education and vocational training facilities, there was a stated intention to reopen it, but there were no concrete plans or exact timeframes. In the meantime, it was providing an efficient mobile

service to prisoners, with around 650 loans a month. However, in our survey, fewer respondents than at the last inspection said that the library had a range of materials to meet their needs, and particularly stark was the fact that no Muslim prisoners surveyed considered this to be the case.

5.5 Gym provision was better than we had recently seen in similar prisons. In our survey, 60% of respondents said that they could access the gym or play sports at least twice a week. This had mainly been achieved by re-purposing space in the works area into a well-equipped and functioning exercise area to supplement the main gym. The published programme had provided for three gym sessions a week, although prisoners told us that a third session was not always offered. There was a very limited offering for remedial gym as the main PE instructor trained to undertake this was on long-term absence. Little was currently being done to promote gym provision to non-users. No team sports were currently offered, but there were plans to resume them.

Recommendation

5.6 **All prisoners should be able to access the library regularly and be consulted about what they need from it.**

Education, skills and work activities

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

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

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

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Inadequate

Personal development: Inadequate

Leadership and management: Inadequate

5.8 The extensive operational staffing shortages at the prison had had a substantial and detrimental impact on prisoners' access to education, skills and work activities. Leaders and managers had not developed a culture that placed an appropriate focus on ensuring that prisoners attended education and training. Leaders and managers did not place sufficient priority on prisoners' education and training to make sure that they were prepared for employment when released.

5.9 Leaders had been too slow to reintroduce education, skills and work. They had not secured sufficient activity spaces for the current prison population. Leaders and managers allowed prisoners too much choice as to whether they engaged in purposeful activity. As a result, very few prisoners undertook education and a large number were unemployed, with not all available spaces being filled (see key concern and recommendation 1.52). Leaders made sure that prisoner pay was not a disincentive to attend education classes.

5.10 Leaders did not make sure that there was sufficient resource available to teach prisoners with low-level English and mathematics skills. In addition, too few prisoners had the opportunity to complete examinations in English, mathematics and English for speakers of other languages (ESOL). Only a few achieved their mathematics or ESOL qualifications (see key concern and recommendation 1.52).

5.11 Staff did not make sure that prisoners completed their in-cell induction packs in a timely manner, due to a large backlog. As a result, too many prisoners could not access education or work as they had not completed the induction. Staff responsible for information, advice and guidance (IAG) made sure that most prisoners had personal learning plans. However, because of the reliance on written communications, and a lack of peer mentors to support the process, there was no opportunity for useful dialogue with prisoners about their career aspirations. This meant that IAG staff provided little helpful information and guidance to prisoners, and too many learning plans were not sufficiently effective or personalised (see key concern and recommendation 1.53).

5.12 Staff did not allocate prisoners to activities appropriately, relying instead on prisoners' own choices. As a result, too many completed in-cell learning or work activities that did not meet their career aspirations, and they did not gain the skills and knowledge that would help them secure employment on release. Too few prisoners were able to access release on temporary licence opportunities for employment or training (see key concern and recommendation 1.53).

5.13 Leaders' work with employers and community agencies was too limited. They had yet to begin liaising with employers to inform the curriculum and the content of programmes offered. Prisoners had very

limited contact with employers and other community organisations to support their preparation for future employment.

5.14 Leaders had completed a thorough training needs analysis of the prison population and considered the local and national employment trends. They had in place clear recommendations for the development of a future curriculum, recognising the importance of English, mathematics and ESOL. They placed a high priority on improving prisoners' digital skills. For example, all prisoners had a laptop computer and telephone in their cell and were able to access digital in-cell learning. The digital skills curriculum was due to recommence as a priority. Leaders also had a clear future vision for embedding sustainability within the curriculum, particularly in relation to construction. However, they had not considered the curriculum needed for all prisoners and, as a result, there was no provision for foreign nationals or for the small proportion of prisoners serving life sentences.

5.15 The curriculum for work activities was not sufficiently ambitious. While work roles had a clear job description and purpose, and orderlies had some supervisory responsibility, too few prisoners had the opportunity to assume higher responsibilities. Most of the work failed to challenge prisoners and was mundane and repetitive.

5.16 Education leaders completed useful audits of the quality of learning and assessment of the in-cell learning materials. While they had accurately identified areas for development and improvement actions, they had been too slow to make sure that a sufficient proportion of prisoners benefited from the good-quality education available and too few accessed face-to-face education. They had been particularly slow to reintroduce vocational training. Leaders and managers had not considered the quality of training that prisoners received in work roles and prison-led workshops, or the progress that they made in learning. Too many prisoners were not challenged by their work. (See key concern and recommendation 1.54.)

5.17 Education staff received a broad range of professional development and updating through training organised by leaders and managers. However, there were too few opportunities for teachers and instructors to improve their skills in teaching and assessment.

5.18 Most instructors made sure that work activities enabled prisoners new to their work areas to learn the required skills and allow for reinforcement over time. For example, in textiles, prisoners began their use of sewing machines on samples and test tasks before sewing the final version of boxer shorts; in gardening, they gradually developed their skills within the context of what was seasonal and what was needed by the kitchens.

5.19 Education staff designed and provided a broad range of high-quality learning packs, supported by digital content, for prisoners to complete in their cells while restrictions were in place. Learning programmes gradually increased in difficulty and included a wide range of activities for prisoners to practice and consolidate the knowledge and skills they

learned. As a result, the small proportion of prisoners who engaged with learning made good progress.

5.20 Most teachers provided meaningful one-to-one support to prisoners to complement in-cell learning. They used their contact time with prisoners effectively to help them recognise the progress they made, provide useful feedback and to identify next steps. As a result, most prisoners made good progress in their learning and could clearly articulate what they had learned.

5.21 Instructors helped prisoners understand what they had done well and what they needed to improve. Prisoners found this information useful and acted on it.

5.22 Prisoners with learning difficulties and disabilities (LDD) were supported effectively in education classes. Specialist staff carried out detailed screening of prisoners identified with a learning support need. Teachers used and refined the well-constructed support plans well. Additional support staff had been appointed to help prisoners with LDD in workshops but had not yet begun.

5.23 Prison instructors did not consider prisoners' existing skills, knowledge and experience when planning training. Most prisoners in work roles and workshops completed their work to an appropriate standard that met the requirements of external customers. However, they did not develop skills and behaviour beyond the requirements of the job.

5.24 Vocational teachers did not make sure that prisoners retained or re-enforced their prior learning during the time that vocational training was closed. They did not provide in-cell work in advance of re-joining, or starting, practical training. As a result, prisoners were not able to make progress in their areas of interest or career aspirations.

5.25 Too many prisoners were not able to achieve qualifications or recognition of any skills and knowledge gained. For example, those in wing worker roles such as waste management, horticulture and kitchens could not access relevant qualifications, including basic food hygiene qualifications for the latter group (see key concern and recommendation 1.54).

5.26 Staff set clear and firm expectations for behaviour in learning and work environments. Prison instructors clearly explained appropriate behaviour concerning health and safety, which prisoners demonstrated in their conduct. For example, they adopted the appropriate processes for the safe movement of trolleys in packing workshops, use of sewing machines in textiles and use of tools in waste management and gardens.

5.27 Prisoners respected each other and staff when learning or at work. Staff were quick to tackle any inappropriate behaviour. Prisoners felt safe when attending work or when working with teachers in a one-to-one environment.

5.28 Many more prisoners were keen to work or learn than the regime allowed. The limited and changing regime and staff shortages had led to some challenging behaviour and demotivation. There were considerable frustrations among prisoners, who felt that they were wasting their time being restricted to their wings. Too many waited a long time to receive their requested in-cell learning pack, and some did not receive it at all despite repeatedly asking for it. The new regime, which began during the inspection, while enabling prisoners to access face-to-face education and vocational training sessions, was not introduced effectively. Leaders' communication to prisoners and staff affected by these changes had been poor.

5.29 Attendance at work and appointments with education staff was too low. Furthermore, prisoners did not attend their activities punctually (see key concern and recommendation 1.52). Too often, they experienced delays in unlocking times or were not unlocked at all in order to attend. Others chose to remain on their wings as there were insufficient sanctions for those refusing to engage in education, skills and work.

5.30 Leaders and managers had not made sure that education, training and work activities enabled personal development opportunities for prisoners. Teachers and instructors did not help prisoners to explore their interests. While a range of in-cell packs on personal development areas, such as managing stress and emotions, equality and diversity, and drug and alcohol awareness, was available, too few prisoners chose to complete them (see key concern and recommendation 1.55).

5.31 Staff did not make sure that education and work activities helped prisoners to further their understanding of values of tolerance and respect. They did not actively promote equality or celebrate diversity through the curriculum. As a result, a large minority of prisoners felt discriminated against, particularly foreign nationals, for whom ESOL lessons had only recently restarted (see key concern and recommendation 1.55).

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 The prison had not done enough to support prisoners to maintain contact with the outside world. A family strategy had been published in 2021, which included relevant priorities, such as improving the parenting skills of prisoners and involving the family in resettlement decisions when appropriate. However, the prison did not have an action plan for how these goals would be achieved and we did not find evidence that work was underway (see key concern and recommendation 1.56).

6.2 In our survey, only 18% of respondents said that staff encouraged them to keep in touch with family and friends. Key work sessions had not been completed routinely (see paragraph 4.2) and we found no evidence of other staff encouraging family contact (see key concern and recommendation 1.56).

6.3 Prisoners could still access secure video calling (see Glossary) four days a week, although not all the available slots were used. In-person visits were available but prisoners could only have two 60-minute visits a month, with no additional sessions for those on the highest level of the incentives scheme. Public transport links to the prison were limited and many prisoners told us that their visitors had a journey of several hours, often including an expensive taxi ride from the train station; they felt that it was not worth asking visitors to endure this for a visit of only one hour. The prison had not asked prisoners what they wanted from the visiting arrangements and had no clear plan for when they would be expanded.

6.4 Arrangements for booking visits were inadequate. They could be booked directly by prisoners on their laptop computers or by visitors using the telephone. However, the demand was too high for the sole member of staff assigned to bookings, and during the inspection there were over 400 missed calls on the booking line and 99 voice messages (the maximum that the telephone could record). Most of the visitors we spoke to said that they had experienced problems getting through on the booking line (see key concern and recommendation 1.56).

6.5 The décor in the visitors' centre was unwelcoming and there were no facilities for refreshments. The visits hall was shabby, with a large hole in the ceiling. However, all the visitors we spoke to said that they had been well treated at the prison.

Visits hall

6.6 There were two family development workers, who did not offer casework support to prisoners and described their role as mainly 'signposting to other sources of support'. Some prisoners we spoke to said that they had not been supported with matters in the family court and there was no record in their case notes about these issues.

6.7 There were no parenting courses for prisoners, and the Storybook Dads programme (in which prisoners record stories for their children) was still paused. The prison had arranged a few family days in 2021, but had not yet agreed a date for these to resume.

Reducing risk, rehabilitation and progression

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

6.8 Many prisoners at Wayland were serving long or indeterminate sentences and about 45% of the population presented a high or very high risk of harm.

6.9 The strategic management of resettlement for a high-risk prisoner group had deteriorated considerably since the last inspection and lacked direction. The prison was not working towards an up-to-date, overarching reducing reoffending strategy and there was no coordinated oversight of data to monitor and improve outcomes for resettlement pathways. Work to reduce reoffending was undermined by the lack of a comprehensive needs analysis and action plan (see key concern and recommendation 1.57).

6.10 Reducing reoffending meetings to oversee delivery of the strategy and prisoner outcomes had not been held for some time, and managers were unable to provide the last set of minutes. Leaders were not sufficiently focused on fulfilling the function of a category C training and resettlement prison (see key concern and recommendation 1.57).

6.11 Most offender management unit (OMU) caseloads were too high. Probation offender managers held approximately 50 cases, with prison offender managers (POMs) holding approximately 100. This was unsustainable and undermined some elements of core practice, and was further compounded by POMs not receiving sufficient training and support.

6.12 The frequency and quality of offender manager sessions were variable, and we found a disparity between probation and prison offender manager case contacts. In the latter group, we came across some cases with no record of the prisoner having been seen in the past 12 months or since their arrival. By contrast, prisoners being managed by probation offender managers were seen over and above the expected frequency, with some well-rounded evidence of sentence progression support and contact with community offender managers (COMs).

6.13 In our survey, 59% of respondents said that they had a sentence plan, and only 39% that staff were helping them to achieve their targets. We found that sentence plans were of uneven quality and that record-keeping did not clearly reflect the progress made and how it translated into sentence progression. While there were some good sentence plan examples, reflecting work completed, many other sentence plan targets had not been updated to consider current circumstances, and in some cases there was room for expansion with more creative and specific ways of addressing risks. While we saw these issues across the board, they were mostly prevalent in sentence plans completed by POMs.

6.14 In the sample of cases we reviewed, most had up-to-date risk management plans which were of a reasonable to good standard. These were generally of better quality than the sentence plans.

6.15 Many prisoners arrived at the establishment without an offender assessment system (OASys) assessment. In the previous six months, of the 486 OASys-eligible prisoners admitted, only 43% had an initial assessment. Additional resources had been allocated to reduce the backlog, such as agency probation offender managers supplied by the HM Prison and Probation Service (HMPPS) OASys task force team,

but more needed to be done, as at the time of the inspection 85 prisoners were overdue an assessment of their risk and needs.

6.16 Although few prisoners were eligible for home detention curfew (HDC), this was reasonably well managed. In the previous 12 months, there had been 87 applications, of which 48 had been approved. A combination of unsuitable accommodation and prisoners arriving at the establishment shortly before or after they qualified for HDC meant that about half of such releases had taken place beyond their eligibility date.

6.17 Approximately one-third of the population were eligible for parole. Offender managers prioritised this group to make sure that the necessary assessments were completed. During the previous 12 months, 168 parole board hearings had taken place, either through video-link or telephone conferencing.

6.18 Use of release on temporary licence (ROTL) had resumed in January 2022, but at the time of the inspection had been paused for security reasons. Only six prisoners had undergone ROTL before suspension of its use. This particularly affected the category D prisoners who remained at Wayland with no way of demonstrating their reduced risks.

Public protection

6.19 Limited resources had led to a deterioration in public protection arrangements. Only one public protection clerk was allocated to this area and, because of other work commitments, they were allotted only one day a week to public protection.

6.20 We found serious weaknesses in initial risk assessment procedures. Not all prisoners whose communications might have needed monitoring because of their offence or other restrictions were identified on arrival. From January 2022 to April 2022, approximately 43 prisoners who potentially required such restrictions had not been identified on arrival and could have spent up to four weeks before this was recognised and rectified at a monthly check.

6.21 There were also weaknesses in the monitoring procedures for those who had been identified. At the time of the inspection, 25 prisoners were subject to mail and telephone monitoring. Of these, in three cases we found that it had wrongfully ended because of a clerical misunderstanding. In previous instances where this had happened, monitoring arrangements had been extended, even though there was no evidence to justify doing so. Furthermore, prisoners subject to mail and telephone monitoring who were not English speakers did not have their communications translated. The content of video calls was not monitored. These weaknesses in public protection arrangements hindered the prison's ability to keep the public safe.

6.22 An interdepartmental risk management meeting was held monthly to review risk management processes. The agenda and terms of reference were appropriate, and a wide range of prisoners was discussed. Attendance at this meeting was not multidisciplinary and

mainly consisted of OMU representatives, but updates were provided from other departments, such as security. There was a suitable focus on high-risk prisoners approaching release, and in all the cases we reviewed in detail, risk management plans were up to date, with most being of a reasonable to good standard.

6.23 Prisoners subject to multi-agency public protection arrangements (MAPPA) were reviewed, and MAPPA management levels confirmed, before release. However, there was not always evidence of MAPPA-specific information sharing with the COM recorded on the HMPPS digital recording systems. Staff participated in community MAPPA meetings through video-conferencing facilities and 21 community MAPPA meetings had been attended in the previous 12 months.

6.24 We examined 10 notifications of prisoner information for potential multi-agency release management assessments (MAPPA F). Overall, these were completed to a good standard, with half of the sample referencing communication with the COM. However, in many cases the assessors did not consistently state when they started managing the case or the frequency of contact, and it was not clear from where information had been obtained.

Recommendation

6.25 **Public protection monitoring should be timely and effective, to reduce the risks of harassment and further criminal activity.**

Categorisation and transfers

6.26 Categorisation procedures were functioning well and few cases were overdue. During the previous 12 months, 939 recategorisation reviews had taken place, with 719 approved for category C and 220 for category D status. We saw little evidence that prisoners were involved in their reviews, but they were informed of the outcome.

6.27 Most recategorisation applications were completed in a timely manner, with appropriate justification and rationale.

6.28 While recategorisation reviews were fairly prompt, prisoners' ability to demonstrate a reduction in their risk levels was limited because of the minimal education and work opportunities available (see section on education, skills and work activities, and key concern and recommendation 1.54), regime restrictions (see section on time out of cell) and long waiting lists for offending behaviour programmes (see paragraph 6.32). For those who were successful, progressive transfers to category D establishments were slow. At the time of the inspection, 51 prisoners were due for a move to open conditions, and some had been waiting approximately six months.

6.29 At the time of the inspection, 143 prisoners were serving life or indeterminate sentences, most of whom were located on a designated wing (E). A large proportion (79%) were beyond their tariff period. There was minimal support for this group, with no lifer forums held and

no peer representative. However, in the previous few weeks, probation offender managers had been allocated an office on E wing in which to base themselves for one day a week. This allowed these prisoners to have weekly contact with the OMU and had been well received by them.

Interventions

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

6.30 As a category C training and resettlement prison, programme delivery was a core function of the establishment. A range of accredited interventions had continued to be offered throughout most of the pandemic, although with reduced numbers because of the COVID-19 restrictions. With such a reduced capacity, prioritisation was given to prisoners with parole or release dates approaching.

6.31 A needs analysis of offending behaviour programmes had not been completed but segmentation data indicated that the programmes offered were relevant to the population.

6.32 Waiting lists for accredited programmes were long and many prisoners complained of the difficulty in completing an intervention, and the impact of this on their ability to progress through their sentence. This inevitably resulted in some being released with unmet offending behaviour needs.

6.33 There was a good range of in-cell programmes in use, corresponding to the range of interventions that was available normally. Prisoners on waiting lists for medium-intensity programmes on thinking skills and building relationships were offered in-cell workbooks, resulting in the completion of some form of offending behaviour work. As most of the population had in-cell laptops (see paragraph 4.21), these workbooks could be delivered with videos to support learning. In just under two years, 172 offending behaviour in-cell workbooks had been completed.

6.34 Our case review sample indicated some creative ways in which the programmes team had made efforts to encourage prisoner engagement, through welfare checks, one-to-one sessions and easing the prisoner back into the group.

Specialist units

Expected outcomes: Personality disorder units and therapeutic communities provide a safe, respectful and purposeful environment which allows prisoners to confront their offending behaviour.

Offender personality disorder units, including psychologically informed planned environments

6.35 At our last inspection, a personality disorder unit and a psychologically informed planned environment unit had been located on Wensum unit (E wing). However, these were no longer in use and had closed down.

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.

6.36 Resettlement provision had deteriorated considerably since the last inspection (see key concern and recommendation 1.58). Around 30 prisoners were released each month and, while there had been some improvement in the number released with suitable accommodation, too many were still discharged with no fixed address. In high-risk cases, accommodation needs were addressed by the COM, who allocated a place in approved premises. Data supplied by the prison indicated that 76% of those released in the previous 12 months had spent their first night in sustainable accommodation.

6.37 With no resettlement worker in post (although a recruited worker was being vetted), support for release was not well coordinated. This gap in provision resulted in a disjointed and inconsistent resettlement service, with no resettlement plans and no oversight of who needed support for release (see key concern and recommendation 1.58).

6.38 Of the cases we reviewed, 10 prisoners were in the pre-release group. We interviewed some of them, who expressed their concerns about the lack of support they received.

6.39 A support worker from the Shaw Trust (a charitable organisation which supports people leaving custody) was available to support prisoners leading up to their release. Some medium- and high-risk individuals received help with applying for identification documents and bank accounts, but, irrespective of risk level, access to this service depended on the proactivity of the prisoner rather than it being offered as a matter of course.

6.40 A housing worker from Interventions Alliance (an organisation that supports prisoners leaving custody to secure accommodation) attended the establishment one day a week to support prisoners to find suitable accommodation in the community. Referrals to this service and outcomes were not monitored.

6.41 A Jobcentre Plus representative was available three days each week. In the sample of pre-release cases we reviewed, a letter was sent to prisoners three months before their release offering support or advice; however, there was no further information to indicate what, if any, follow-up actions had been taken.

6.42 Practical support for prisoners on their day of release was minimal and mainly consisted of providing suitable clothes, if needed.

Section 7 Recommendations in this report

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

Key concerns and recommendations

7.1 Key concern 1.46: The governor had made a good start in setting some clear and positive priorities, of which many staff were aware. However, they were very broad and had not yet been turned into a practical programme of change that was clear to all. Although there was good analysis of data in many aspects of prison life, it was not yet leading to coherent programmes of action with clear success criteria. Strategic meetings to drive improvement and delivery in key areas had only recently resumed. These included reducing reoffending, and oversight of the use of force.

Recommendation: The governor and senior managers should plan and communicate to all staff a clear programme for improvement in the establishment, based on data, driven through effective governance and engagement, and with clear criteria for measuring success.
(To the governor)

7.2 Key concern 1.47: Challenge, support and intervention plans (CSIPs) were not used widely or to full effect to manage perpetrators and victims of antisocial behaviour. There was little to motivate and encourage prisoners to improve their behaviour.

Recommendation: CSIPs should be used effectively to manage all those who are involved in, or victims of, violence and antisocial behaviour, and the incentives scheme should encourage prisoners to behave well.
(To the governor)

7.3 Key concern 1.48: As a result of the serious staff shortages, wings did not have a consistent staff group who knew the prisoners who lived there. The delivery of key work had fallen away, and only 20% of respondents to our survey said that in the previous week a member of staff had asked them how they were getting on. We saw many examples of staff not challenging low-level rule-breaking in communal areas, such as prisoners vaping, being improperly dressed, and shouting and swearing.

Recommendation: Prisoners should receive adequate supervision and support from staff on the wings, and live in an environment where expected standards of behaviour are known and upheld.
(To the governor)

7.4 Key concern 1.49: The violence reduction policy was mainly generic and not focused on the unique factors at the establishment that may have caused violence, such as the high prevalence of alcohol and drugs.

Recommendation: The violence reduction policy should be based on the specific issues at the establishment and should include an action plan for addressing the high levels of violence and its underlying causes.
(To the governor)

7.5 Key concern 1.50: While administering medication, health care staff had experienced some unacceptable behaviour from prisoners and were put at serious risk. The safety of health staff while transporting controlled drugs around the prison had sometimes been compromised by prison staff allowing prisoners along the route. There was insufficient officer support and management of medicine queues to promote patient confidentiality, lessen the opportunities for diversion and bullying, and support safe medicine administration.

Recommendation: Measures should be put in place urgently to protect health care staff from physical attacks while administering medication. Prison staff should supervise medicine administration and the transportation of medicines, including controlled drugs, effectively to make sure that security is not compromised, promote patient confidentiality, and prevent diversion and bullying.
(To the governor)

7.6 Key concern 1.51: The regime for prisoners had changed and time out of cell, including for exercise and structured association, had been reduced for many.

Recommendation: Access to purposeful activities should be expanded while maintaining sufficient time out of cell for all prisoners.
(To the governor)

7.7 Key concern 1.52: Leaders had not provided sufficient education, skills and work activities for all prisoners, and too many were not attending their allocated activities. Leaders had been too slow to reopen education classes, work and vocational training, and too many prisoners were unemployed. There was insufficient resource to meet the needs of the prison population in relation to English and mathematics.

Recommendation: Leaders should swiftly increase the availability of and attendance at activities, particularly in education and vocational training, so that prisoners are able to gain the skills and knowledge they need for employment when they are released, including improving essential English and mathematics skills.
(To the governor)

7.8 Key concern 1.53: Leaders and managers did not make sure that prisoners received useful, timely information, advice and guidance (IAG), and that they were allocated to activities that met their future employment goals and development needs.

Recommendation: Leaders should make sure that IAG staff engage appropriately with prisoners to establish their career goals and specific training needs. Staff should make sure that prisoners are allocated to activities that will help them to achieve their career goals.
(To the governor)

7.9 Key concern 1.54: Leaders and managers had not considered the quality of training that prisoners received in work roles and prison-led workshops. Too many prisoners were not challenged by their work and they were not able to achieve qualifications, or recognition of any skills and knowledge gained.

Recommendation: Leaders should identify and implement actions that will improve the quality of training and activities in prison-led work areas, so that prisoners are challenged to make progress. Prisoners should be able to achieve qualifications or have their new skills and knowledge recognised.
(To the governor)

7.10 Key concern 1.55: Leaders and managers had not made sure that education, training and work activities enabled personal development opportunities for prisoners. Teachers and instructors did not promote the importance of equality, inclusion or values of tolerance and respect, or help prisoners to explore their interests.

Recommendation: Leaders should make sure that the curriculum provided through education, skills and work helps prisoners to extend their knowledge and understanding beyond the subject being studied or their specific job role.
(To the governor)

7.11 Key concern 1.56: In our prisoner survey, only 18% said that staff encouraged them to keep in touch with family and friends. The visits offer for prisoners was still not good enough, and those who had progressed to the highest level of the incentives system could not access additional sessions. Arrangements for booking visits were inadequate, and most of the visitors we spoke to said that they had experienced long delays trying to do this. The visitors' centre remained unwelcoming, with no facilities for refreshments, and the visits hall was shabby. There was no casework support for prisoners with family matters and there were no parenting courses.

Recommendation: The prison should make sure that prisoners have easy access to visits, as well as support to develop and maintain family ties.
(To the governor)

7.12 Key concern 1.57: The strategic management of resettlement had deteriorated considerably since the last inspection and lacked direction. The prison was not working towards an up-to-date, overarching reducing reoffending strategy and there was no coordinated oversight of data to monitor and improve outcomes for resettlement pathways. Work to reduce reoffending was undermined by the lack of a comprehensive needs analysis and action plan.

Recommendation: There should be a prison-wide reducing reoffending strategy and action plan, supported by a comprehensive needs analysis.
(To the governor)

7.13 Key concern 1.58: Resettlement provision had deteriorated considerably since the last inspection. With no resettlement worker in post, support for release was not well coordinated. This gap in provision resulted in a disjointed and inconsistent resettlement service, with no resettlement plans and no oversight of who needed support for release.

Recommendation: Staff should have a clear understanding of the resettlement needs of the population. Services delivered by resettlement partners should be coordinated effectively and quality assured so that the provision meets the need.
(To the governor)

Recommendations

7.14 Recommendation 3.9: All prisoners should receive a thorough and multidisciplinary induction, after their vulnerabilities and risks have been properly explored on arrival.
(To the governor)

7.15 Recommendation 3.17: There should be formal support for victims of antisocial behaviour or violence.
(To the governor)

7.16 Recommendation 3.31: Oversight and scrutiny of the use of segregation should be robust and contribute to improvements, including consistent reintegration planning.
(To the governor)

7.17 Recommendation 3.39: The strip-searching of prisoners, and their handcuffing on escort, should be based on a full risk assessment and be proportionate to the risks posed.
(To the governor)

7.18 Recommendation 3.40: Mandatory drug testing should be reinstated.
(To the governor)

7.19 Recommendation 3.50: Prisoners at risk of self-harm or suicide should be given good support through the assessment, care in custody and teamwork (ACCT) process, and those self-isolating should be

supported through discussing the reasons and working towards reintegration.
(To the governor)

7.20 Recommendation 4.19: Food should be prepared and served in safe and hygienic conditions.
(To the governor)

7.21 Recommendation 4.43: The prison should explore the reasons why prisoners with disabilities feel unsafe and/or experience bullying, and address the issues that are identified.
(To the governor)

7.22 Recommendation 4.47: Prisoners should receive weekly corporate worship.
(To the governor)

7.23 Recommendation 4.73: Patients should be able to access all health services promptly, to improve attendance and reduce waiting times.
(To the governor)

7.24 Recommendation 4.89: The transfer of patients to hospital under the Mental Health Act should occur within agreed Department of Health timescales. (Repeated recommendation 2.92)
(To the governor)

7.25 Recommendation 5.6: All prisoners should be able to access the library regularly and be consulted about what they need from it.
(To the governor)

7.26 Recommendation 6.25: Public protection monitoring should be timely and effective, to reduce the risks of harassment and further criminal activity.
(To the governor)

Section 8 Progress on recommendations from the last full inspection report.

Recommendations from the last full inspection

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

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2017, conditions in reception and first night accommodation were less than ideal but processes were sound. The number of assaults had reduced from a peak in 2016 but remained very high. Measures to analyse and reduce violence were thorough and applied consistently. The level of self-harm had risen and was high; there was room for improvement in the monitoring of those at risk but there was a purposeful and coordinated approach to addressing issues at establishment level. The level of use of force was high, and its governance was inadequate. Security arrangements were generally proportionate, and the flow of intelligence had improved; there was a strong emphasis on the urgent task of reducing the ready availability of drugs. The segregation unit, in spite of inadequate physical facilities, was well managed. Work to address substance misuse was reasonably good. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

The number of assaults should be reduced substantially through violence reduction measures, the efficacy of which should be monitored continuously. (S69)
Not achieved

The establishment should continue to focus on reducing the supply and use of new psychoactive substances, and a comprehensive needs analysis should inform an action plan with clear and measurable objectives to reduce both demand and supply. (S70)
Not achieved

Recommendations

Prisoners should be offered comfort breaks at least every two and a half hours. (1.3)
Not achieved

Assessment, care in custody and teamwork (ACCT) documentation should be completed properly. Triggers should record possible future events that might cause self-harm, while actions in care plans should be relevant and signed off when completed. (1.16)
Not achieved

All staff should have up-to-date training on safer custody and ACCT procedures. (1.17)
Not achieved

Searching and suspicion drug testing should be sufficiently resourced to carry out all actions which are identified as required on the basis of intelligence, and any slippage should be monitored and addressed. (1.28)
Achieved

Prisoners on the basic regime should be set individual and realistic targets to address their poor behaviour. (1.32)
Not achieved

Analysis of adjudication data should include all protected characteristics, and the senior management team meeting should routinely consider adjudications data. (1.35)
Partially achieved

The use of force committee should provide adequate oversight, review all uses of force and ensure that all dossiers are completed properly. (1.38)
Partially achieved

The segregation unit should be fit for purpose, with adequate hygiene facilities. (1.42)
Not achieved

The Rehabilitation of Addicted Prisoners trust (RAPt) service should be sufficiently resourced to develop initiatives such as peer support and work with families, and post-programme support for prisoners in recovery should be increased, in partnership with the prison. (1.49)
Achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2017, the accommodation was kept reasonably clean. The new prisoner net books for daily administrative tasks and in-cell telephones were making a positive impact. Staff–prisoner relationships were reasonably constructive and confident. Some good work was done on equality but black and minority ethnic and Muslim prisoners reported more negatively than their counterparts. Provision for those with disabilities was inadequate. The chaplaincy provided a good service. Complaints were handled efficiently but replies were not always of adequate quality. Most health services were reasonable, except for the management of long-term physical conditions. Mental health provision was good as far as it went, but

did not meet the full range of need. Perceptions of the food provided were not favourable, and standards of hygiene were inadequate. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

Managers should work consistently with all prisoners with protected characteristics, especially those with disabilities, and black and minority ethnic and Muslim prisoners, to establish and implement satisfactory ways of addressing their needs and concerns. (S71)
Partially achieved

The kitchens should be adequately equipped for the proper storage and separation of food types, and catering staff should, on the basis of full training, store food in accordance with hygiene standards and ensure that religious and cultural needs are met. (S72)
Not achieved

Recommendations

Two prisoners should not share cells meant for one. (2.9)
Not achieved

All toilets should be appropriately screened. (2.10)
Not achieved

The decaying cell floors on the newer wings should be repaired and the in-cell showers deep cleaned. (2.11)
Not achieved

Cell call bells should be answered within five minutes. (2.12)
Not achieved

Foreign national prisoners should be regularly consulted and have access to independent immigration advice. (2.31)
Not achieved

Use of the professional telephone interpreting service should be monitored and should reflect the number of non-English speakers. (2.32)
Not achieved

Prisoners with disabilities should be systematically identified on reception, and needs for reasonable adjustments and other support should be met throughout their time at the establishment. (2.33)
Partially achieved

The chaplaincy should provide an official prison visitor scheme. (2.37)
Not achieved

The chaplaincy should establish links with London faith communities to support prisoners near release. (2.38)
Partially achieved

All complaints should be dealt with fairly and responded to with a resolution or comprehensive explanation of future action. (2.42)
Not achieved

Prisoners should have easy access to a wide range of up-to-date legal textbooks, Prison Service Instructions and information about the Criminal Cases Review Commission and Legal Ombudsman. (2.44)
Achieved

Prisoners should be able to work on their legal cases using word processing packages. (2.45)
Achieved

All clinical staff should be in date with basic life support training. (2.60)
Achieved

When prisoners receive out-of-hours care, their medical record should be updated immediately, to ensure that ongoing treatment and advice are acted on. (2.61)
Achieved

A single health care complaints system should be in operation, and it should be well advertised. (2.62)
Achieved

There should be regular systematic health promotion campaigns. (2.63)
Achieved

Prisoners should not have to rely on prison officers in order to access health care triage services. (2.70)
Achieved

Prisoners with long-term conditions should receive regular reviews and have evidence-based care plans developed and delivered by competent health professionals. (2.71)
Achieved

Medication administration should be fully supervised by prison staff, to ensure confidentiality and prevent diversion. (2.78)
Not achieved

All prisoners should have the facility to lock away in-possession medication. (2.79)
Not achieved

In-possession reviews should be completed in line with a policy that is up to date. (2.80)
Achieved

For medicines that are deemed critical, follow-up should take place for missed or refused doses sooner than 72 hours. (2.81)
Achieved

The transfer of patients to hospital under the Mental Health Act should occur within agreed Department of Health timescales. (2.92)
Not achieved (recommendation repeated, 4.89)

Social care assessments should be undertaken within the timescale accepted in the community. (2.95)
Achieved

Food temperature logs and associated management checks should be completed on all wings, ensuring cleanliness and good practice in serveries. (2.99)
Not achieved

More effective consultation should take place to understand and address prisoners' concerns about the food. (2.100)
Achieved

Prisoners should have access to the full shop ordering system within 24 hours of arrival at the establishment. (2.104)
Achieved

Purposeful activity

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

At the last inspection, in 2017, there were sufficient activity places but the amount of time out of cell was relatively low. Learning and skills and work activities were well managed, with an emphasis on improving practice. Work activities were generating more recognised qualifications. The range of learning opportunities was appropriate to the population, although progression routes needed improving. Standards of teaching and learning were good, particularly in digital media. There was strong skill development in vocational training. Attendance was reasonable and prisoners had positive attitudes to learning. The library was well stocked and run but access to it was poor. PE facilities were adequate but underused. Outcomes for prisoners were reasonably good against this healthy prison test.

Recommendations

Prisoners who are not at work through no fault of their own should be unlocked during the core day. (3.5)
Not achieved

Employed prisoners should have equal access to exercise time. (3.6)
Partially achieved

There should be effective pre-release provision, to help prisoners to gain employment or further training. (3.13)
Not achieved

Following assessment, prisoners should be told what they need to do to improve. (3.25)
Achieved

Classroom teaching should take account of individual skill levels to ensure that prisoners are appropriately challenged. (3.26)
Achieved

Teachers should use prisoners' starting points to plan learning effectively. (3.27)
Achieved

Prisoners should be able to study English and mathematics alongside their vocational training. (3.28)
Not achieved

Prisoners should be allocated to work and education in line with their skills action plans and career aspirations. (3.29)
Not achieved

The sequencing of activities, particularly vocational training courses, should be more effective, to allow prisoners to progress through levels quicker and more easily. (3.30)
Not achieved

There should be good rates of attendance at learning and skills and work activities. (3.36)
Not achieved

Library access should be improved. (3.44)
Not achieved

Prisoners not attending the library should be encouraged to do so. (3.45)
Not achieved

Gym staff should promote the use of the gym to prisoners not currently attending. (3.49)
Not achieved

Resettlement

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

At the last inspection, in 2017, the overall management of resettlement work was reasonable. The offender management unit struggled in the face of the number of prisoners arriving with no offender assessment system (OASys) assessment but staff had worked hard to reduce the backlog. The quality of their work was reasonably good but sentence plans were not driving individual prisoner progress. Public protection and categorisation procedures worked well but there was little provision for those serving indeterminate sentences. Reintegration planning was carried out reasonably well. Much of the resettlement pathway work was sound. Weekly children and family visits were run but work with families was otherwise underdeveloped. Offending behaviour programmes were well organised, with some innovative projects, but there were gaps in inter-departmental communication. Outcomes for prisoners were reasonably good against this healthy prison test.

Recommendations

The reducing reoffending strategy and action plan should be kept up to date. (4.4) The reducing reoffending strategy and action plan should be kept up to date.
Not achieved

Officer offender supervisors should have sufficient time, training and supervision to deliver their responsibilities effectively. (4.11)
Not achieved

Prisoners should not be transferred without an up-to-date offender assessment system (OASys) assessment and sentence plan. (4.12)
Not achieved

Assessment and planning to manage the risk of harm posed by prisoners should be robust, and this should be subject to quality assurance. (4.13)
Partially achieved

There should be regular communication and joint working between the offender management unit and other departments, to ensure that the sentence plan drives all work undertaken with the prisoner. (4.14)
Not achieved

All risk assessments should be informed by a current OASys assessment. (4.20)
Not achieved

The specific needs of indeterminate-sentenced prisoners should be ascertained through consultation, and should inform service provision where appropriate. (4.23)
Not achieved

Basic custodial screenings should be completed to a reasonable quality across the estate. (4.26)
Achieved

All prisoners should be discharged into sustainable accommodation. (4.28)
Not achieved

All prisoners should be offered an effective pre-release course to prepare them for education, training or employment. (4.31)
Not achieved

The virtual campus should be used to help prisoners in their development of job search skills. (4.32)
Not achieved

Managers should analyse whether prisoners are successfully released into education, training or employment. (4.33)
Not achieved

Prisoners with substance misuse needs should be able to have training on overdose management, including the use of naloxone, before their release. (4.37)
Achieved

Facilities in the visitors centre should be improved, to cater for friends and family arriving after long journeys. (4.45)
Not achieved

A strategy to help prisoners maintain and strengthen family links should be developed and implemented. (4.46)
Not achieved

Appendix I About our inspections and reports

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

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

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

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

Respect
Prisoners are treated with respect for their human dignity.

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

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

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

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

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

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

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

Our assessments might result in one of the following:

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

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

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

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

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

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

This report

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

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

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

Inspection team

This inspection was carried out by:

Charlie Taylor	Chief Inspector
Martin Kettle	Team leader
Sumayyah Hassam	Inspector
David Owens	Inspector
Tamara Pattinson	Inspector
Christopher Rush	Inspector
Rebecca Stanbury	Inspector
Nadia Syed	Inspector
Dionne Walker	Inspector
Charlotte Betts	Researcher
Rachel Duncan	Researcher
Emma King	Researcher
Alec Martin	Researcher
Maureen Jamieson	Lead health and social care inspector
Paul Tarbuck	Health and social care inspector
Peter Biggs	Pharmacist
Lynda Day	Care Quality Commission inspector
Gary Turney	Care Quality Commission inspector
Rebecca Jennings	Ofsted inspector
Tilly Kerner	Ofsted inspector
Montserrat Perez	Parent Ofsted inspector
Rebecca Perry	Ofsted inspector
Martin Ward	Ofsted inspector

Appendix II Glossary

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

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

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

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

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

EMDR (eye movement desensitisation and reprocessing)
This is a form of psychotherapy that helps individuals to process and recover from past experiences that are affecting their mental health and well-being.

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

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

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

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

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

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

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

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

Appendix III Further resources

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

Prison population profile

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

Prisoner survey methodology and results

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

Prison staff survey

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

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

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

Printed and published by:
Her Majesty's Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
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