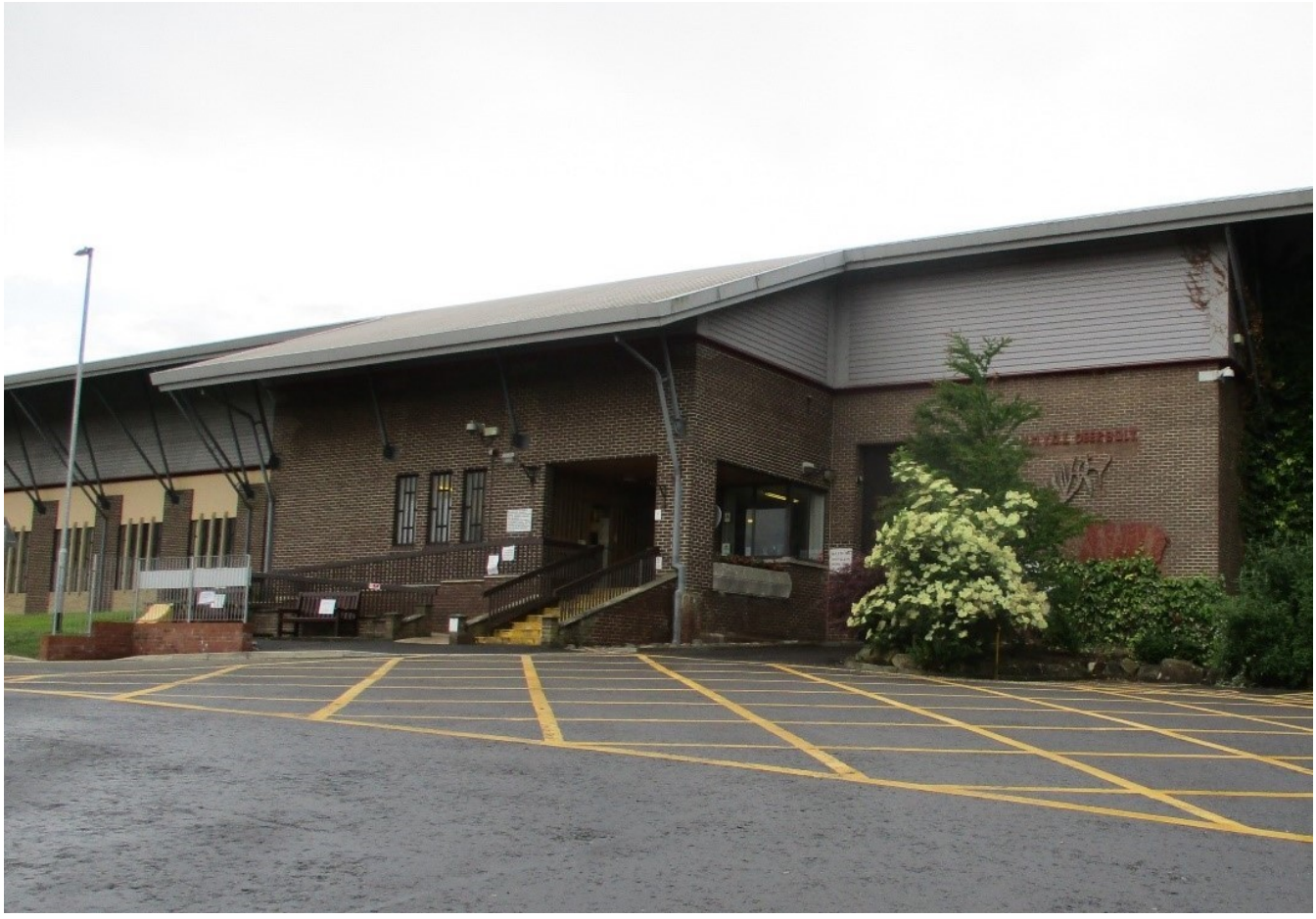
Report on an unannounced inspection of

HMP/YOI Deerbolt

by HM Chief Inspector of Prisons

21 June – 9 July 2021



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Introduction

Deerbolt is a prison and young offender institution located near to Barnard Castle in County Durham. The establishment is normally capable of holding more than 500 young adult prisoners aged 18 to 24 years old, but a rolling programme of refurbishment and upgrades meant that this number had been dramatically reduced and only 265 prisoners were held at the time of our visit. Of these, nearly two-thirds were under the age of 21.

When we last inspected Deerbolt in 2018 we found a prison that was reasonably safe and respectful, but one that surprisingly, bearing in mind the resources available, needed to improve the regime experienced by those detained and its approach to the rehabilitation and resettlement of prisoners about to be released. At this inspection we again found a mixed picture, showing a deterioration in safety outcomes and the quality of regime, but improvement in work towards resettlement.

Deerbolt had been impacted significantly by the COVID-19 pandemic which partly explained the deterioration of the regime. Leaders and managers had taken effective action to minimise the spread of the virus, although at the time of our visit the prison had been declared an outbreak site for the third time in recent months. One prisoner and six members of staff had tested positive and a larger group of staff were isolating after being contacted by NHS test and trace. All prisoners and staff had been offered the vaccine and regular testing was available. This is important context, but it remained the case that the experience was very poor for these young prisoners who were typically spending 23 hours a day locked in cell with little structured activity. The impact of this on prisoners was stark and much more needed to be done, and greater ambition shown, in making sure that more work, education and recreational activity was reintroduced as a priority. This was particularly disappointing given the large amounts of outdoor space at the prison.

In contrast, the prison had made commendable improvements to sentence planning and risk management arrangements and we were confident there were plans in place to develop this work further. Similarly, we noted some good work to support care leavers and the introduction of a new and interesting initiative to support young people as they transitioned to Deerbolt from juvenile facilities during their sentence. Outcomes in health care, mental health care and social care were likewise much improved and ensured some positive outcomes.

It was clear to us that the governor had a vision for Deerbolt's future, but it was perhaps less clear how progress would be measured or how and when the vision could be realised. During the inspection itself, leaders did make some improvements in response to our feedback and findings. While welcome, this confirmed to us a somewhat reactive approach to issues and the absence of a useful plan which identified priorities and timeframes for progress. Oversight of violence reduction measures, for example, was poor, which led to a response that was reactive and limited rather than one which dealt with the underlying conflict and issues. This will need to be addressed as the regime improves.

Deerbolt is a prison which retains great potential. We encourage leaders and managers to show greater confidence in the restoration and development of the regime and make better use of the extensive space. We also encourage them to develop a more consultative and ambitious approach with prisoners that expects more of them and incentivises their engagement with what the prison is able to offer.

Charlie Taylor
HM Chief Inspector of Prisons
July 2021

About HMP/YOI Deerbolt

Task of the prison/establishment
HMP/YOI Deerbolt is a closed male young offender institution (YOI) and category C training prison for young adults up to the age of 24, receiving prisoners from across the country.

Certified normal accommodation and operational capacity (see Glossary of terms)
Prisoners held at the time of inspection: 265
Baseline certified normal capacity: 539
In-use certified normal capacity: 347
Operational capacity: 337

Population of the prison
- 25 foreign national prisoners are currently held.
- 63% of prisoners are aged under 21.
- 33% of prisoners are from black and minority ethnic backgrounds.
- 221 prisoners had been released into the community in the last 12 months.
- 96 prisoners were receiving support for substance use.
- 98 prisoners were being supported by the mental health team.

Prison status (public or private) and key providers
Public

Physical health provider: Spectrum Community Health CIC ('Spectrum')
Mental health provider: Tees, Esk and Wear Valleys NHS Foundation Trust
Substance use treatment provider: Humankind and Spectrum
Prison education framework provider: Novus
Community rehabilitation company (CRC): No longer relevant
Escort contractor: GeoAmey

Prison group/Department
Tees & Wear Prison Group

Brief history
Deerbolt was opened in 1973, on the site of an old army camp. It is situated on the outskirts of Barnard Castle, a historic market town.

Short description of residential units
I wing: The induction and first night wing and current reverse cohort unit, consisting of 60 cells.
K wing: A small unit used to transition prisoners from youth custody, holding up to 16 prisoners.
A, D and F wings: Currently closed for refurbishment.
B and C wings: 60 cells.
E wing: 66 cells.
G wing: 36 cells.
J wing: 39 cells.
Segregation unit: 13 cells and two special accommodation cells.

Name of governor/director and date in post
Andy Hudson, June 2018

Leadership changes since the last inspection
Pete Walker, March 2018 to June 2018

Prison Group Director
Alan Tallentire

Independent Monitoring Board chair
Charlies Ing

Date of last inspection
16–27 April 2018

Section 1 Summary of key findings

1.1 We last inspected HMP/YOI Deerbolt in 2018 and made 52 recommendations, three of which were about areas of key concern. The prison fully accepted 38 of the recommendations and partially (or subject to resources) accepted 10. It rejected four of the recommendations.

1.2 Appendix 7 contains a list of recommendations made at the last full inspection.

Progress on key concerns and recommendations

1.3 Our last inspection of HMP/YOI Deerbolt 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 one recommendation about a key concern in the area of safety. At this inspection, we found that this recommendation had been achieved.

1.5 We made one recommendation about a key concern in the area of purposeful activity. At this inspection, Ofsted carried out a progress monitoring visit alongside our inspection to assess the progress that leaders and managers had made towards reinstating a full education, skills and work curriculum. They judged that it was too early to assess whether recommendations made at the last inspection had been achieved.

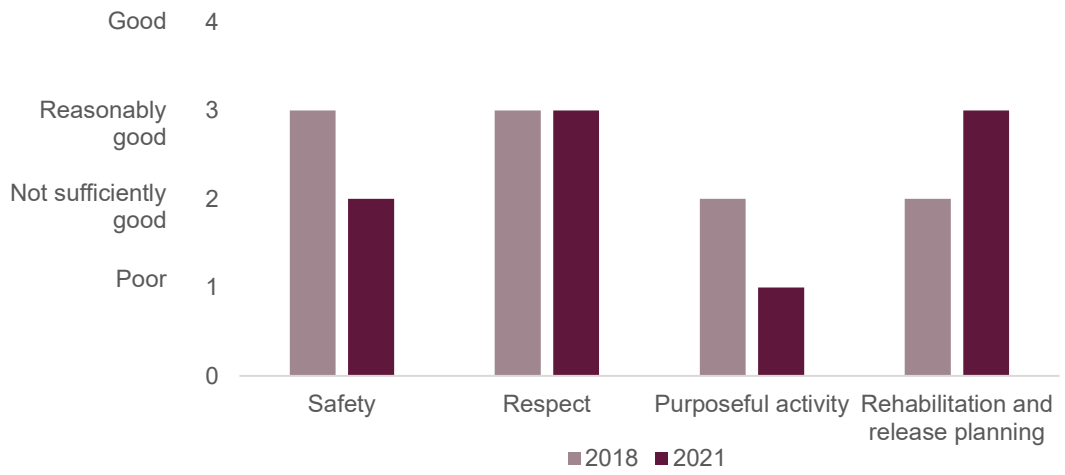
1.6 We made one recommendation about key concerns in the area of rehabilitation and release planning. At this inspection, we found that this recommendation had been achieved.

Outcomes for prisoners

1.7 We assess outcomes for prisoners against four healthy prison tests (see Appendix I for more information about the tests). At this inspection of HMP/YOI Deerbolt, we found that outcomes for prisoners had stayed the same in one healthy prison area, improved in one and declined in two.

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

Figure 1: HMP/YOI Deerbolt healthy prison outcomes 2018 and 2021



Safety

At the last inspection of HMP/YOI Deerbolt, in 2018, 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 against this healthy prison test.

1.9 The reception area had been improved by the provision of private space for interviews. Reception processes were relatively swift, and staff were welcoming. Cells for new arrivals were clean and adequately equipped but looked shabby. The regime for new arrivals during their 14 days on the reverse cohort unit (see Glossary of terms) was limited to one hour's mixing each day with others who had arrived within 24 hours of their admission. In our survey, fewer prisoners than at the time of the previous inspection said that they had had an induction, and only just over half of these said that this had told them all they needed to know about the prison. The transitions unit, while a promising addition to the support offered to prisoners coming from the youth custody estate, needed further development.

1.10 Levels of violence had reduced and were similar to those at comparator prisons. Systems for challenging perpetrators and supporting victims of bullying and violence were in disarray and had resulted in some prisoners being held in segregation conditions without the appropriate safeguards. There were very few meaningful incentives for prisoners who engaged with the regime and behaved well.

1.11 Despite attempts to improve governance of use of force, there remained weaknesses. We reviewed a sample of incidents and raised concerns with senior leaders over practice observed in several of these incidents. Special accommodation had been used six times in the last six months, but prison records did not always justify adequately its use.

1.12 The number of prisoners segregated had fallen in line with the population. Prisoners in segregation spoke well of the staff on the unit, although the regime and environment were poor.

1.13 The number of incidents of self-harm had reduced during the pandemic and was lower than at similar prisons. The generally good support for prisoners on assessment, care in custody and teamwork (ACCT) case management for those at risk of suicide or self-harm was undermined by the poor regime, which reduced opportunities for spontaneous supportive interaction with staff and other prisoners. The constant supervision cells provided a very poor environment. There had been little use of Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners).

Respect

At the last inspection of HMP/YOI Deerbolt, in 2018, 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 against this healthy prison test.

1.14 In our survey, more prisoners than at the time of the previous inspection said that most staff treated them with respect. Meaningful interaction between staff and prisoners was limited by the regime and some opportunities were missed. However, we saw examples of personalised, supportive input from staff and some relaxed informal conversations. Key work was very limited.

1.15 A programme of refurbishment was under way and included the installation of in-cell telephony. External areas were pleasant, but exercise yards were stark. Prisoners were not provided with coats and we saw some using bin bags to protect them from the rain. Cell conditions were generally reasonable. However, toilets were dirty and most remained unscreened. The flooring in too many cells needed repair. The process to allow prisoners access to their property was poor and many were frustrated by this. Arrangements for consulting prisoners were poor and the resolution of matters raised was slow.

1.16 Prisoners' perceptions of the food had improved and the new healthy options were well received. Prisoners had no access to self-catering facilities, and they continued to eat all meals in their cells.

1.17 Strategic oversight of equality and diversity had been impacted adversely by COVID-19 restrictions. The diversity equalities monitoring team (DEMT) had continued to meet, but there had been no consultation with prisoners in protected groups and there was little analysis of data, both of which undermined its effectiveness. Work to raise awareness of protected characteristics had been limited, but the quality assurance of responses to discrimination incident report forms was good. A third of the population was from a black and minority

ethnic background. In our survey, these prisoners reported more negatively than their white counterparts across a range of questions. There was insufficient support for the 25 foreign national prisoners at the establishment. Faith provision was good and corporate worship had recently restarted.

1.18 In our survey, 75% of respondents said that the overall quality of health services was good, and prisoners we spoke to were positive about health care provision. The prison and health care providers had worked diligently, in close collaboration with Public Health England, to make sure that prisoners' health needs continued to be met during the COVID-19 restrictions. Primary care services were very good and all services had resumed following the COVID-19 restrictions.

1.19 The prison, Durham County Council and Spectrum provided exemplary access to social care assessments and packages of care and support to those meeting the threshold.

1.20 The responsive mental health team was easily accessible and the prisoners we spoke to valued the support it offered. However, those needing transfer to secure mental health inpatient services continued to wait far too long for a bed.

1.21 Substance misuse services were very good but subject to inefficiencies due to the lack of access to electronic clinical records, and failures to attend appointments because of regime and allocations limitations.

1.22 Medicines management arrangements were generally safe. However, medicine queues were not sufficiently well supervised and health care staff's observation of compliance was poor.

Purposeful activity

At the last inspection of HMP/YOI Deerbolt, in 2018, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection, we found that outcomes for prisoners were now poor against this healthy prison test.

1.23 Ofsted carried out a progress monitoring visit of the prison alongside our full inspection and the purposeful activity judgement incorporates their assessment of progress. Ofsted's full findings and the recommendations arising from their visit are set out in Section 4.

1.24 The regime was inadequate and prisoners were frustrated by the slow pace of change. Most prisoners spent 23 hours each day locked in their cells with little useful activity to fill their time. Access to time in the fresh air was limited to 30 minutes a day. The lack of meaningful activity meant that many prisoners spent most of their days bored or asleep in their cells. We had concerns about the impact of the lack of normal

social interaction on the well-being of a long-term young adult population.

1.25 Prisoners could not attend the library in person, but there was good use of the order and delivery service that it operated. Gym sessions were appreciated by prisoners, but staffing issues had resulted in some being cancelled.

1.26 Leaders and managers had made sure that most prisoners had access to some form of education, skills or work, although this was mostly limited to in-cell education packs. The prison appropriately had prioritised the participation in remote learning of prisoners with learning needs and/or disabilities and those who need to improve their English or mathematics skills.

1.27 Induction was undermined by an over-reliance on written information being sent to prisoners. Many of the induction packs were not returned by prisoners.

1.28 Information, advice and guidance arrangements were relatively new and not yet effective. As a result, not all prisoners enrolled on education courses that related to their interests or career aspirations.

1.29 The small number of prisoners in industry workshops took pride in their work and developed well their life skills and the vocational knowledge and behaviour needed to succeed following release.

1.30 Most learning packs were of a good standard. However, reinforcement of prisoners' learning through the linking of theory with practical application was not possible for many. In addition, these packs did not challenge more able prisoners sufficiently. Prisoners in education classes did not have routine access to the relevant information technology and telephony needed to support their development.

Rehabilitation and release planning

At the last inspection of HMP/YOI Deerbolt, in 2018, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection, we found that outcomes for prisoners were now reasonably good against this healthy prison test.

1.31 A full-time family support worker had provided a good service to prisoners. This service had stopped when the community rehabilitation company contract ended, but it had been recommissioned and was due to restart. Social visits had restarted recently but were very limited in number. Access to telephones was limited on those wings without in-cell telephony. Secure Video Calls (see Glossary of terms) were popular and leaders had made them available during the evenings, when prisoners' families were most accessible.

1.32 Strategic oversight of offender management was good. The strategy was effective and well informed and linked to an action plan that was well managed and drove change. Every prisoner had an assessment of their needs and risk, and a sentence plan. Around two-thirds of these had been reviewed in the last 12 months. The quality of sentence plans that we reviewed was mostly good; there was good engagement between the prison and community offender managers before release. Home detention curfew processes were timely and external housing support was effective. Re-categorisation reviews were well managed and most prisoners were moved on within reasonable timescales.

1.33 Public protection arrangements were effective. The interdepartmental risk management team meeting routinely considered those due for release at appropriate intervals, to make sure that their risks were managed appropriately.

1.34 Delivery of accredited programmes had restarted following the pandemic restrictions, and there were plans to address the backlog that this had caused. However, some prisoners had been discharged without being able to complete needed offending behaviour work. The care leaver support worker provided a good service to prisoners.

1.35 There was a 'through-the-gate' service, which engaged with every prisoner and provided good support with their resettlement needs. Employment, training and education outcomes were not fully coordinated through the prison offender manager, which meant that the prison and probation service may not have been aware of all aspects of a prisoner's release arrangements.

Key concerns and recommendations

1.36 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.

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

1.38 Key concern: There were few meaningful incentives to motivate positive behaviour among young adult prisoners. The regime offered few opportunities for progress to be supported or recognised among those who engaged constructively with their sentence plan or the wider custodial experience. The existing and limited incentives scheme was not applied equitably.

Recommendation: Managers should review the prison's approach to incentives in all aspects of prison life. Rewards and incentives that are meaningful to prisoners and which recognise and support those who engage with the regime and behave well should be introduced.
(To the governor)

1.39 Key concern: Processes to manage victims and perpetrators of violence (challenge, support and intervention plans) were in disarray. Only serious incidents of violence were investigated. Subsequent plans to manage victim and perpetrators lacked detail, wing staff were unsure of who was subject to monitoring and why, and there was no managerial oversight of the process, including reviews. As a result, some prisoners were locked up for several weeks without meaningful human contact, welfare checks or any indication as to when the restrictions would end. There was no system to resolve conflicts between prisoners swiftly, which meant that the default response was to keep prisoners apart, rather than help them resolve their issues.

Recommendation: Oversight of violence reduction measures should make sure that all incidents of violence are investigated swiftly and that victims and perpetrators are challenged and supported appropriately.
(To the governor)

1.40 Key concern: Despite some improvements in governance, weaknesses in use of force practice were not always identified by the prison or referred subsequently to the governor for further investigation. Due to poor recording and accountability, some footage of incidents from body-worn cameras was now unavailable. Special accommodation had been used six times in the last six months, and prison records did not demonstrate that there had been adequate justification or that it had been necessarily used as a last resort.

Recommendation: Use of force and use of special accommodation should be more accountable with concerning incidents promptly and properly investigated and opportunities for learning and improvement usefully exploited.
(To the governor)

1.41 Key concern: The segregation unit was bleak. Cells, showers and exercise yards were in poor condition and there was no in-cell electricity. It required urgent refurbishment. Apart from a basic regime entitlement of a daily shower, telephone call and half an hour's outdoor exercise, there was little to engage, stimulate or encourage positive behaviour. Multi-unlock staffing levels were routine, without documented authority or daily reviews to check if they remained appropriate.

Recommendation: The purpose of segregation, and the regime and environment that support it, should be to prioritise meeting the specific needs of individuals, provide support to improve their behaviour and develop an approach that encourages and incentivises their re-engagement with the prison regime.
(To the governor)

1.42 Key concern: The key work scheme was not functioning at the time of the inspection. This lack of regular meaningful interaction was of concern, given the potential impact of continuing restrictions on prisoners' well-being and progression.

Recommendation: Managers should make sure that every prisoner has regular contact with a key worker who can address their welfare needs and progression goals.
(To the governor)

1.43 Key concern: Consultation arrangements were poor and the resolution of issues was very slow. Prisoners had become disengaged from the consultative process as they felt that they were not taken seriously, and that the prison failed to act on the concerns they raised.

Recommendation: There should be ongoing, meaningful consultation with prisoners, with their issues and concerns addressed and resolved in an accountable way.
(To the governor)

1.44 Key concern: There had been no consultation with prisoners in protected groups, which undermined the DEMT's effectiveness, and there was little work with prisoners to promote protected characteristic groups. Black and minority ethnic prisoners reported more negatively than their counterparts in our survey. There was little analysis of data relating to the treatment and experience of those with protected characteristics. Actions from the DEMT meeting often took too long to resolve.

Recommendation: There should be consultation with prisoners in protected groups, and detailed analysis of the data relating to the treatment and experience of these prisoners. This should be used to identify and address any differences in treatment leading to more equitable outcomes.
(To the governor)

1.45 Key concern: Prisoners needing a transfer to hospital under the Mental Health Act waited far too long for a bed.

Recommendation: The local delivery board, in conjunction with NHS England and Improvement, should make sure that transfers to secure mental health inpatient units under the Mental Health Act take place within the national timescale of 28 days.
(To the governor)

1.46 Key concern: Continuing integration of the work of the substance misuse team with physical health, clinical management and mental health teams and the efficiency of joint care delivery were being hampered by lack of access to SystmOne, the inability to co-locate mental health and drug and alcohol recovery teams, and lost appointments due to regime and allocations challenges.

Recommendation: Challenges to the continuing integration of the work of Spectrum, Tees, Esk and Wear Valleys, and Humankind staff should be resolved by the local delivery board.
(To the governor)

1.47 Key concern: Many prisoners spent up to 23 hours in their cells each day with too little to do. Progress to improve the poor regime had been slow. We were concerned about the impact on the well-being and progression of young prisoners, who had limited opportunities to talk to staff, socialise with peers or maintain their relationships with loved ones; were not kept physically or mentally active; and spent only 30 minutes each day in the fresh air.

Recommendation: Time out of cell and access to activity should be improved and increased.
(To the governor)

1.48 Key concern: At the time of the inspection, no prisoners could access group lessons, either on the wing or in classrooms. This hindered substantially the development of those prisoners who learnt best through direct teacher contact.

Recommendation: Leaders and managers should expand the learning offer by introducing wing- and classroom-based learning sessions as soon as is practically possible. They should provide prisoners with access to relevant information technology resources and enough mentoring support to help them progress.

1.49 Key concern: Most prisoners had limited access to the telephone, with only 10 minutes allowed each day. There was no availability on some wings for prisoners to make telephone calls in the evenings, when their families were most accessible.

Recommendation: All prisoners should have access to the telephone at least once a day, for a duration and at a time that supports meaningful family contact.
(To the governor)

Notable positive practice

1.50 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.

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

1.52 Health care staff spoke to all prisoners who had been subject to the use of force, to gather their views on the incident and the aftercare they

received. This information was shared, with consent, with health and prison leaders, and informed practice. (See paragraph 3.40.)

1.53 Community offender managers were invited to dial in as part of the interdepartmental risk management team meeting, which supported strong risk management and information sharing. (See paragraph 5.14.)

1.54 There was a care leavers support worker, who provided excellent one-to-one bespoke support for prisoners who had recently left local authority care. A large number of prisoners had been identified as needing this service, with each seen individually to assess their need. Advocacy services, resettlement planning and support, housing and help with forming links in the community were all provided, as well as group work and peer support outside of the pandemic restrictions. (See paragraph 5.22)

Section 2 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

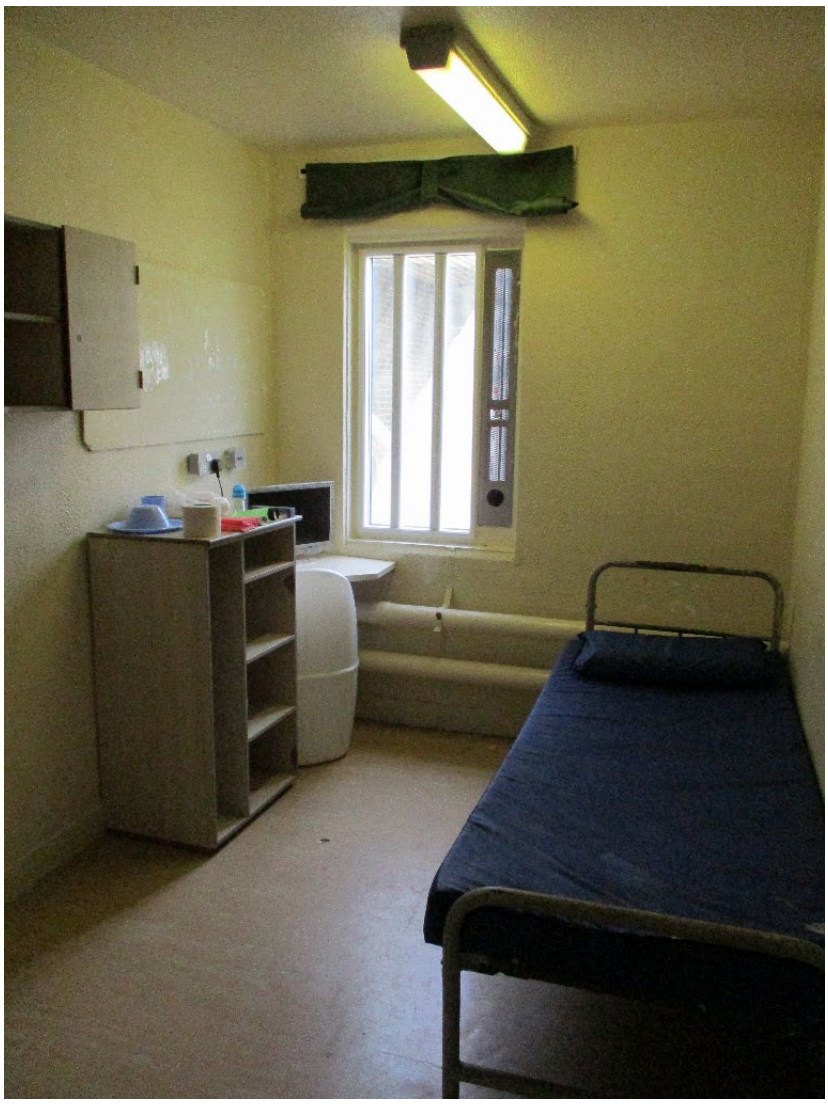
Expected outcomes: Prisoners transferring to and from the prison are safe and treated decently. On arrival prisoners are safe and treated with respect. Risks are identified and addressed at reception. Prisoners are supported on their first night. Induction is comprehensive.

2.1 The number of new arrivals had decreased over the previous year, to an average of 12 each week, usually arriving from other prisons during the afternoon. The escort vehicle we saw was new, clean, graffiti-free and suitably equipped for the journey. There were no undue delays in prisoners' entry to the reception area and they were not handcuffed when leaving the escort vehicle. Reception processes were completed promptly, but the strip searching of new arrivals needed to be properly justified if used in addition to the body scanner.

2.2 In our survey, 81% of prisoners, similar to the number at the time of the previous inspection, said that they had been treated well in reception. Staff were welcoming and the reception area had been improved by the addition of a private interview room, seating in the reception area and the provision of some small holding rooms that had been risk-assessed for occupancy during the pandemic. These were not locked routinely when prisoners were in them, but they contained too little information about the prison. A peer worker provided hot drinks for new arrivals and spent time with each individually before they left reception.

2.3 During the receptions we observed, prisoners' property was processed on the day of arrival, so they could have it with them in their first night cell. While in reception, prisoners could buy some prison shop items, including a vape pack, and telephone credit, with payment spread over several weeks.

2.4 New arrivals, except for transitions from the youth custody estate (see below), went to I wing, where they were interviewed confidentially by first night and health care staff. The first night cells we saw during the inspection looked shabby but were clean and adequately equipped. New prisoners could have a free telephone call and a shower before being locked up and additional checks were in place on their first night at the prison. In our survey, 86% of respondents said that they had felt safe on their first night.



First night cell on I wing

2.5 There were no speaker phones to support the COVID-19-safe use of professional telephone interpreting services in reception or on the first night units, limiting access for those with limited English (see recommendation 3.27).

2.6 New arrivals spent 14 days subject to COVID-19 reverse cohort arrangements (see Glossary of terms), mixing only with other prisoners who had arrived within 24 hours of their admission. Their regime was very limited and resulted in about 23 hours a day in cell, unless they were involved in induction activity. Fewer prisoners than at the time of the previous inspection said that they had received an induction, and only just over half of these said that the induction material told them all they needed to know about the prison. A range of agencies visited inductees during their first two weeks but too much induction activity relied on written information.

2.7 The transitions unit on K wing was part of a pilot to improve transition arrangements for prisoners received from the youth custody estate after their 18th birthday. It introduced some promising initiatives, such as better coordination with the children's estate to plan transition in

good time before a child turned 18 and the use of a maturity screening tool to inform work with prisoners on the unit. However, the unit needed further development to fulfil its purpose. For example, the regime needed significant improvement and staff needed to complete training to enable them to better deliver the 'Choices and Changes' toolkit of short interventions which were designed for use with young adults.

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

2.8 Levels of violence had reduced by approximately 20% since the last inspection. There had been a total of 183 assaults in the last 12 months, which was comparable to that at similar prisons. Assaults on staff averaged around three a month, but there had been six in June 2021, one of which was serious.

2.9 There were significant shortcomings in the response to violent incidents. Perpetrators and victims of violence were managed under the challenge, support and intervention plan scheme (CSIP; see Glossary of terms). However, the scheme was in disarray. Many CSIP investigations were never started and others were incomplete. Managers and staff were often unclear about who was responsible for carrying out the investigations and plans derived from the CSIPs lacked meaningful detail. Frontline staff were often unsure of who was on a CSIP, for how long or why. Most prisoners we spoke to who were subject to a plan were unaware of its details and had not been provided with a copy of it. Plans were not made available to staff routinely, and were not tracked, monitored or reviewed with prisoners. We found some prisoners on a CSIP who had been locked up all day – apart from 20 minutes to take a shower and make a telephone call – for several weeks, with no measures to safeguard their welfare and make sure they had regular, meaningful human contact. Subsequent oversight and management arrangements were similarly poor.

2.10 In the absence of effective challenge or support for perpetrators or victims of violence there was an overreliance on keeping prisoners in conflict apart from each other by moving them to different units. This had reduced the number of violent incidents and was possible while the regime was restricted by COVID-19. The lack of interventions to investigate and address the underlying causes of bullying and violence created a risk as COVID-19 restrictions started to be lifted and the regime improved. We were concerned that there was no plan in place to address this risk.

2.11 Leaders and managers needed to focus on providing short- and longer-term incentives linked to sentence planning targets for prisoners who wanted to progress. The incentives policy had been produced by the regional team and there was little difference between the various levels. In addition, the lack of meaningful work or education further limited the incentives for prisoners who wanted to engage with the regime at Deerbolt (see key concern and recommendation 1.39).

Adjudications

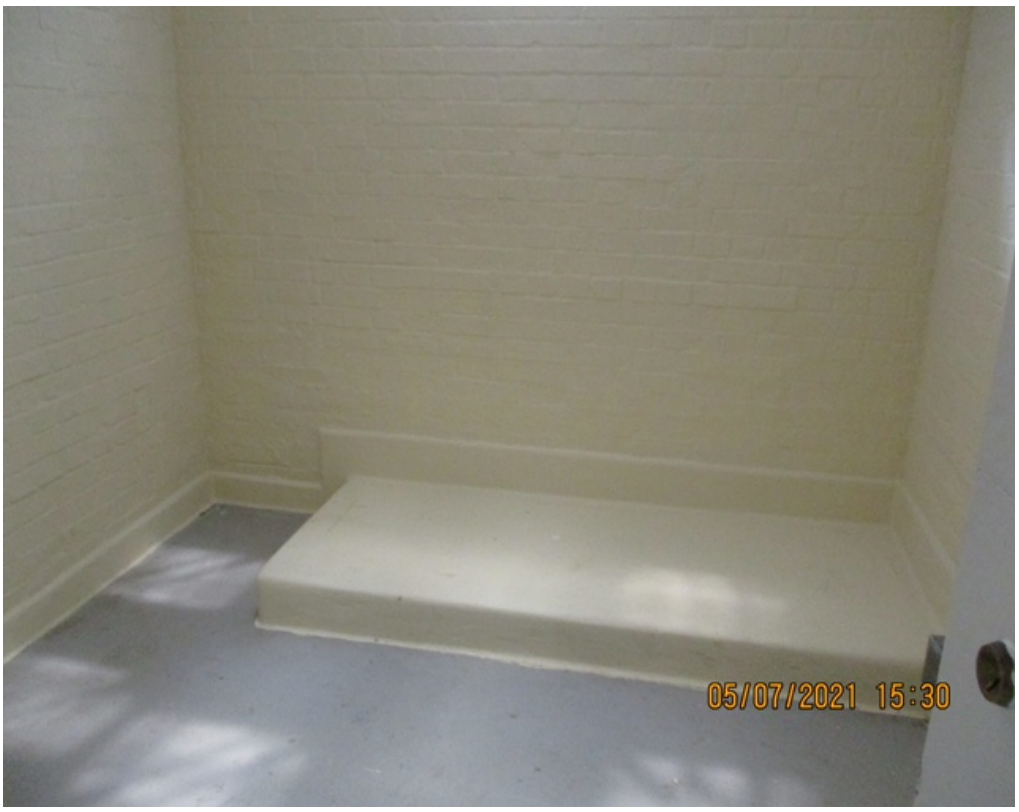
2.12 The number of adjudications had fallen since the last inspection, with 734 in the previous 12 months. Managers ensured that only the most serious of charges were heard which was appropriate. Enquiry into the charges we looked at had been adequate and a senior leader had recently carried out quality assurance. However, at the time of the inspection 78 adjudications had been adjourned over the previous 12 months and 36 were waiting for a police decision dating back two years, which was too long.

Use of force

2.13 Use of force levels had reduced and were now similar to comparable establishments. The use of force coordinator viewed all footage of incidents and provided advice and guidance to staff where there were shortfalls. In addition, the use of force committee looked at 25% of incidents, which was an improvement from the last inspection. The committee also scrutinised the number of outstanding use of force reports at each meeting and, as a result, the backlog was very small. Staff recorded most incidents on body-worn cameras and the use of these was monitored.

2.14 However, some shortfalls remained. Prisoners were not debriefed by prison staff after every incident and footage for two incidents in the selection we reviewed was missing. Where footage was available we identified concerns with practice in several incidents and referred them to managers (see key concern and recommendation 1.40).

2.15 Three members of staff were carrying PAVA (see Glossary of terms), but it had never been discharged, batons had been used three times in the last six months. The two unfurnished cells were stark and had been used six times in the six months before our inspection, one period lasted three days. Scrutiny of unfurnished accommodation was poor and we were not assured its use was always justified (see key concern and recommendation 1.40).



Special accommodation cell

Segregation

2.16 The number of prisoners segregated had reduced and reflected the reduction in the general population. During this inspection, seven prisoners were being segregated under Prison Rule 45 (good order and/or discipline (GOOD)).

2.17 The segregation unit was bleak, with many cells in poor condition. Only one of the two showers worked, and the exercise yard remained as barren as we observed at the last inspection. None of the cells had access to electricity, other than a light switch and cell call bell. The regime on the unit was minimal, with half an hour on the exercise yard, time for a telephone call and shower, and a visit by the duty governor and nurse every day. However, in our survey, 73% of those who had been segregated in the last six months said that they had been treated well by staff on the unit, 82% said that they had been able to shower every day and 91% said that they had been able to use the telephone daily if they had credit (see key concern and recommendation 1.41). Although these reasonably positive views were confirmed in our discussions with segregated prisoners, many admitted to being bored and frustrated due to a lack of interventions or engagement to meet their needs.

Segregation unit exercise yard

2.18 Some prisoners held in the segregation unit were subject to multi-staff unlock protocols. It was unclear why these arrangements were in place, why they had been authorised or when they would be reviewed. When we raised our concerns with managers, a review then took place and restrictions were lifted for some prisoners. It remained unclear, however, how such oversight will be sustained in the future.

2.19 Reintegration plans lacked detail and did not link into the GOOD reviews, which were held weekly in most cases. The reviews were chaired by the duty governor, which meant that there was inconsistency from one review to the next. Most prisoners spent an average of 10 days in segregation and most returned to the wings. However, one prisoner had been segregated for over 140 days with no exit plan.

2.20 The segregation monitoring and review group met monthly but had not identified the shortcomings above. In addition, there was no analysis of data to identify any disproportionality in segregation for those with protected characteristics (see Glossary of terms).

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.

2.21 Security managers received a good flow of intelligence ensuring they identified appropriate threats. There was good information sharing with other prison departments, including the offender management unit and safety team.

2.22 Most security measures were proportionate, although, despite the proper and consistent use of the body scanner, all new arrivals were also strip-searched without an assessment of risk. The implementation of a dedicated search team of six officers was at odds with the limited security threats that the prison had identified, but leaders said that the group was useful for developing security-related work.

2.23 The drug strategy policy was adequate, and meetings were well attended by staff from relevant departments. This work was undermined by a lack of intelligence-led testing since March 2021. Mandatory testing had only taken place in January and June 2021, with no results recorded. When we talked to managers about this, it became evident that although these tests had been carried out, the samples not been sent off for testing, which undermined the process and showed weakness in local systems.

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

2.24 Taking into account the prison's current reduced population, levels of self-harm had reduced during the previous year and were lower than at similar prisons. In the 12 months to May 2021, an average of five prisoners a month had self-harmed: 73 recorded incidents of self-harm in total. There had not been any deaths in custody since the last inspection.

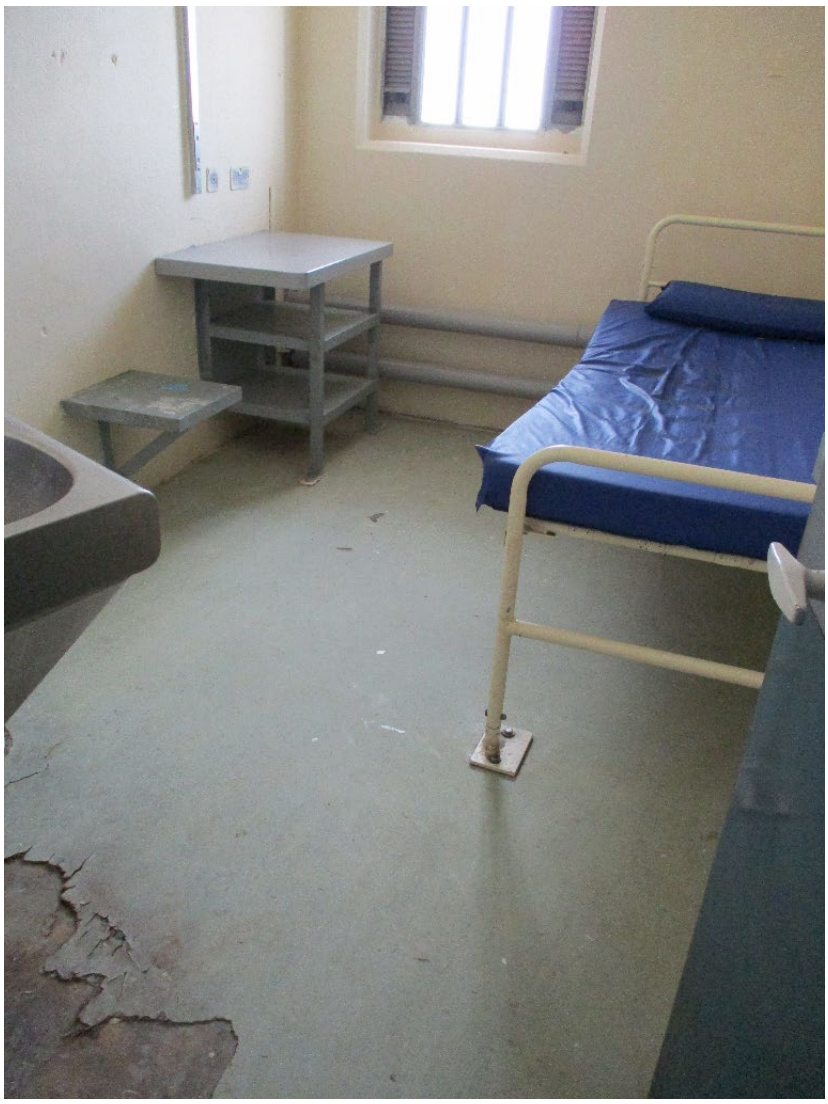
2.25 The monthly safer prisons meeting had continued to meet via telephone during the pandemic, with attendance from across the prison. It considered a range of data and was supported by the weekly safety intervention meeting, which reviewed prisoners with multiple

needs. Managers were trying to develop their use of data to support a more strategic approach at the meeting, although the prison had yet to coordinate this approach through a strategic safer prisons plan, instead working to actions arising from the monthly meeting. This prevented a clear overview of their objectives for the work.

2.26 In our survey, 62% of respondents who had been supported by assessment, care in custody and teamwork (ACCT) case management procedures said that they had received good care from staff. Those we spoke to who were currently or had recently been on an ACCT were mostly positive about the support provided, but said that being locked up alone for long periods with little to do was difficult, and reduced their opportunities for spontaneous supportive interaction with staff and other prisoners. A total of 114 new ACCTs had been opened in the previous year. The holding of prisoners in segregation while on ACCT management was authorised by a governor, who then case managed them.

2.27 The prison implemented the new version of ACCT during the inspection. This had been preceded by awareness sessions for staff and there was written guidance in residential unit offices. Casework was of a reasonable standard overall. In most cases, notes of reviews evidenced informed discussions and consideration of the observation and conversation levels needed, and care plan actions. There was good attendance at reviews by health care and mental health staff. Chaplains made daily checks on all prisoners subject to ACCT case management.

2.28 Constant supervision had been used seven times in the previous 12 months. The constant supervision cells provided a poor, austere environment for prisoners in crisis.



Cell on G wing used for constant supervision

2.29 The prison had six Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners), but records showed only one use of Listeners in 2021 to date. Managers were aware of this under-use, had plans to raise awareness of the Listeners, were recruiting to increase their numbers and had recently identified a suitable location for a new Listener suite where prisoners and Listeners could speak privately.

2.30 When we made an evening test call to the prison's safer custody line, for family and friends to raise concerns about prisoners, it was answered immediately.

Protection of adults at risk (see Glossary of terms)

2.31 The prison's safety policy and staff awareness guide included relevant information about raising safeguarding concerns. The prison was not represented at the local safeguarding adults board and it was not clear how their input would be sought if, for example, a concern about neglect, abuse or trafficking was identified.

Section 3 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.

3.1 In our survey, more prisoners than at the time of the previous inspection said that most staff treated them with respect and that someone had spoken to them in the past week about how they were getting on. This was consistent with our observations during the inspection, although opportunities for meaningful interaction were limited by the regime, which meant they were often merely transactional. Other opportunities for interaction were missed; for example, we saw staff supervising prisoners on the exercise yards at a distance and without any useful engagement. There were exceptions to this, and we did see some staff and prisoners engaged in relaxed, informal conversations and some personalised support being provided (see key concern and recommendation 1.42).

3.2 During the pandemic, well-being checks had been conducted in place of key work sessions (see Glossary of terms). Key work sessions were being reintroduced, initially on a weekly basis for an identified group of prisoners and monthly for all others. However, electronic case notes showed that key work remained very limited. There were long gaps between meaningful entries for many prisoners; for example, in one case there had not been any recorded interaction (other than a negative entry and an incentives warning) by residential staff for four weeks before the inspection.

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

3.3 A programme of refurbishment was under way at the time of the inspection, and as a result three wings, including some of the worst accommodation, were closed. The remaining accommodation was shabby and in a poor state of repair and decoration. There had been ongoing problems with the maintenance contractor, which had hindered

the prison's ability to rectify issues in a timely manner. Association rooms were spacious, but unused at the time of the inspection (see section on purposeful activity). Although external areas were pleasant, exercise yards were stark, with nothing to occupy prisoners.

3.4 All prisoners were accommodated in single cells. Cell conditions were mixed. Most were furnished adequately and had curtains. However, many toilets were dirty and remained unscreened, and there were no rubbish bins. The flooring in many cells was peeling away and dirty. Some of the cells had graffiti, but the offensive displays policy was generally well enforced. In our survey, 64% of prisoners said that they got cleaning materials every week, but during the inspection many complained to us about the poor quality of the cleaning products they were given.

3.5 In our survey, 99% of respondents said that they could shower each day. Most showers provided enough privacy and were adequate, although refurbishment work had not been completed in all areas.

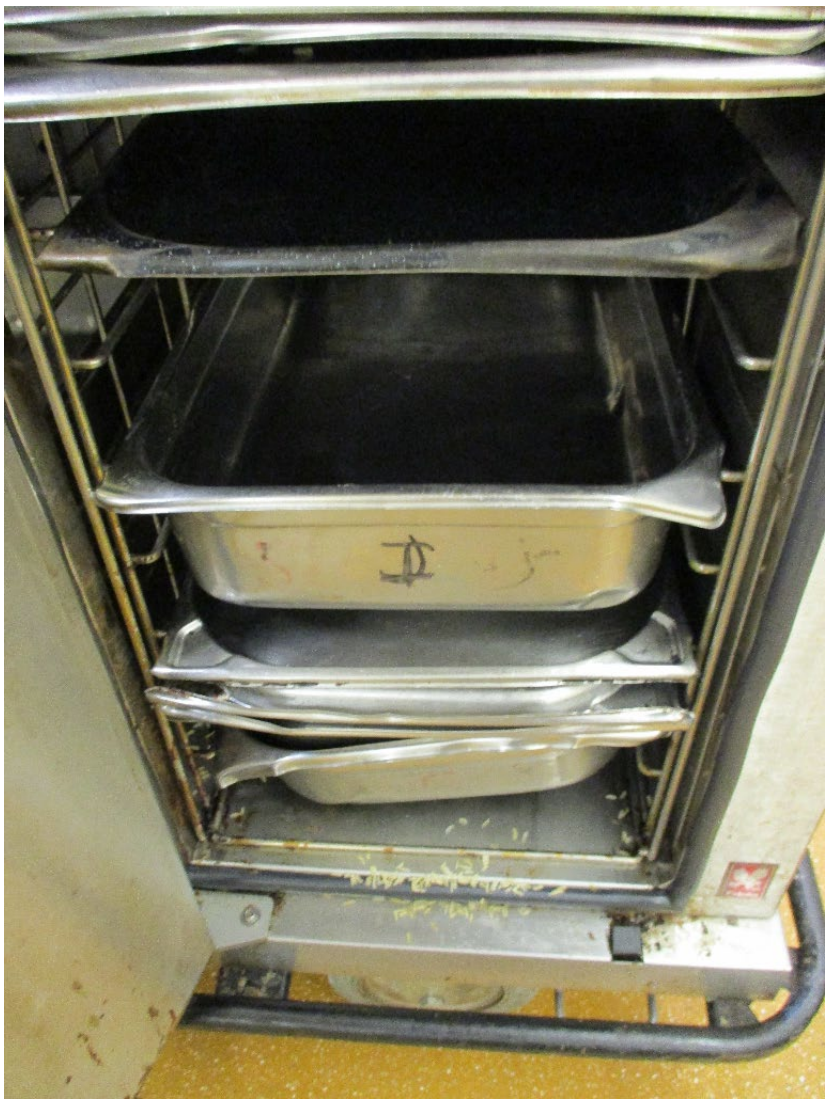
3.6 All prisoners, except those on the bronze level of the incentives scheme (see section on encouraging positive behaviour), could wear their own clothes. In our survey, 81% of respondents said that they had enough suitable clean clothes each week. However, during the inspection we observed prisoners using bin bags as coats while outside in the rain. They told us that if they did not have their own coat, the prison would not provide one. There were no laundry facilities on any of the wings. Many prisoners we spoke to washed their clothes in the sink in their cells because items of clothing went missing regularly when sent to the main laundry, so they had lost confidence in this process.

3.7 Only 12% of prisoners in our survey said that they could obtain their stored property if they needed it. There was no systematic process to allow access to this, and prisoners told us that they were frustrated by this as it took too long to arrange. Many also complained that they were not allowed to have clothes sent in by their families.

Residential services

3.8 In our survey, more respondents than at the time of the previous inspection said that the food provided was very or quite good (53% versus 35%).

3.9 The food was adequate and met dietary requirements. The new menu (see paragraph 3.11) contained healthy meal options, including fruit, which were well received. Prisoners had the choice of a hot or cold option for both lunch and the evening meal. Breakfast packs were available on each wing for prisoners to collect at the same time as their evening meal, for consumption the following day. Prisoners were able to collect food from the wing serveries, but had to eat it in their cell, often next to an unscreened toilet (see paragraph 3.4). Serveries were not always cleaned after use and trollies used to transport food from the kitchen to the serveries were dirty and poorly maintained.



Food trolley on E wing

3.10 The kitchen was reasonably clean, although some flooring was damaged. Refrigerators and freezers were cramped and disorganised. Kitchen workers wore overalls and hair nets. Prisoners working in the main kitchen could not work towards formal catering qualifications and had not received the statutory food hygiene, handling and allergy training. There was no access to self-catering facilities on the wings.

3.11 Although consultation regarding the food did take place changes took too long to implement and actions often rolled over from one month to the next (see paragraph 3.14). Food comment books were available, but they were located behind the servery, which meant that, other than those working in the servery, prisoners did not have access to them, so there were very few comments in them. Prisoners we spoke to were largely unaware of these.

3.12 In our survey, only 52% of respondents said that the shop sold what they needed, compared with 74% at the time of the last inspection. Many prisoners we spoke to were critical of the prison shop and catalogue arrangements. For example, some told us that they could no longer order bedding from an external supplier and now had to buy it

from the prison shop, which was more expensive. When we spoke to leaders about this, there was some confusion, with some confirming and others denying that this was the case. During the inspection, leaders decided that prisoners could resume buying bedding as they had previously. Much of this confusion was caused by the lack of effective communication and consultation between leaders and managers at the establishment (see paragraph 3.14).

3.13 New prisoners could buy a reception pack containing basic food and drink items, and those without money were offered an advance. However, as at the time of the previous inspection, newly arriving prisoners could then wait up to 11 days before they received their first full order, which was too long. They still had to pay a 50 pence handling charge for catalogue orders, which remained inappropriate.

Prisoner consultation, applications and redress

3.14 Consultation arrangements with prisoners were poor. A prisoner consultation meeting, which prisoner representatives attended, occurred monthly but meeting minutes showed that progress in resolving matters was very slow. Examples included a failure to publish the latest menus or to revise the stock list in the prison shop, despite commitments to prisoners to do so. Some prisoners we spoke to said that they had disengaged from the prisoner consultative process as they felt that matters raised were not taken seriously (see also paragraph 3.11, and key concern and recommendation 1.43).

3.15 In our survey, only 45% of respondents said that applications were usually dealt with fairly, and 20% that they were usually dealt with within seven days, both figures being similar to those at the time of the last inspection. The applications process was not quality assured. Received applications were logged, but responses were not, so it was not possible to confirm whether applicants had had received a response, or the quality of that response. Some prisoners we spoke to said that they did not receive responses to their applications.

3.16 A total of 391 complaints had been submitted in the previous 12 months. Only 25% of prisoners in our survey said that complaints were usually dealt with fairly, and 16% that they were dealt with within seven days, again similar to the situation at the time of the last inspection. In our survey 38% of prisoners told us that they had been prevented from making a complaint. When we raised this, managers were unaware of these perceptions but undertook to investigate the reasons. In the sample of complaint responses we reviewed, most were polite, but some lacked sufficient investigation into the issues raised. They were quality assured, but there was no monitoring of responses by prisoners' protected characteristics.

3.17 There was no dedicated support to help prisoners with their legal problems. A limited range of legal textbooks was available in the library, but despite 25 foreign national prisoners being held (see paragraph 3.26), there were no texts on immigration law. The prison handbook was out of date by three years.

3.18 In our survey, only 18% of respondents said that it was easy to book legal visits, which was poor. Prison staff telephoned solicitors when the latter sent privileged mail to a prisoner, to check that it was genuine. Even when the solicitor confirmed that it was, there was a further delay before it was delivered, while it was checked by a sniffer dog. We found correspondence from solicitors waiting a week to be delivered to prisoners. In our survey, 66% of respondents who had received privileged legal correspondence said that it had been opened when they were not present. The prison's records indicated that seven privileged letters had been opened in error in the previous three months, but there were no records available before this. One other letter had been opened when the drug dog indicated that it contained illicit substances.

Equality, diversity and faith

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

Strategic management

3.19 Strategic oversight of equality and diversity had been impacted adversely by the COVID-19 restrictions. The diversity equalities monitoring team (DEMT) had continued to meet, but there had been no consultation with prisoners from protected groups, which undermined its effectiveness (see key concern and recommendation 1.44).

3.20 There was little analysis of data at the DEMT meetings to monitor the treatment and experience of those with protected characteristics. For example, there were some such data on the use of force and allocation to activities, but it was not clear what was done with these or how they were used to inform strategy. The few actions which were generated in these meetings often rolled on from month to month (see key concern and recommendation 1.44).

3.21 Despite the availability of data on black and minority ethnic prisoners, there was little evidence that leaders were analysing this systematically to identify and address concerns (see below).

3.22 Thirteen prisoner equality representatives provided their peers with a point of contact on equality and diversity issues and attended the monthly meetings. However, the limited time out of cell during the pandemic had imposed constraints on what they could achieve.

3.23 A total of 17 discrimination incident report forms had been submitted in the previous six months. The quality of initial responses to those submitted were mostly adequate. Shortcomings had been picked up by

the deputy governor when quality assured, and there were examples where, following this, a more in-depth investigation had taken place.

Protected characteristics

3.24 Some work had been done to raise awareness of protected groups, but this was limited to signage in staff-only areas, promotional literature, quizzes and themed menus. Many prisoners we spoke to were largely unaware of these.

3.25 Thirty-three per cent of the population was from a black and minority ethnic group. In our survey, these prisoners reported more negatively than their counterparts on a range of areas, including encouragement to attend work and keep in touch with family, and having access to managers (see key concern and recommendation 1.44).

3.26 There were 25 foreign national prisoners at the establishment at the time of the inspection, representing around 10% of the population. There was insufficient support for this group. There had been no consultation with them, and no monitoring data on their treatment were collated. Home Office immigration staff had not attended the prison because of the pandemic. They did provide a remote service and there were plans for these visits to restart shortly after the inspection. Foreign national prisoners could have a free five-minute telephone call each month.

3.27 Professional telephone interpreting services were not used routinely for prisoners whose first language was not English. Leaders were unable to provide data in relation to the use of telephone interpretation and there was little information translated into other languages. The library had a small selection of foreign language books.

3.28 At the time of the inspection, one prisoner was being held under immigration powers after completing his sentence. Unlike in immigration removal centres, the Legal Aid Agency did not provide detainees with access to immigration legal advice surgeries, a failing which the High Court had recently found to be unlawful. The Home Office had not informed the prison that one detainee might have been a victim of modern slavery and that it had assessed him to be at risk under its policy, Adults at Risk in Immigration Detention (see Glossary of terms). Staff we spoke to in the prison had not heard of the policy, and there had therefore been no consideration about whether he should be given a wing care plan.

3.29 In our survey, 28% of respondents said that they had a disability; in most cases, this related to mental health, and learning and educational needs. Prisoners with disabilities reported similar treatment and conditions to others on all such questions in the survey. Most of those we spoke to reported reasonable treatment by staff. Although those with personal emergency evacuation plans were identified, some staff on night duty had poor awareness of these. Health care staff provided good support to prisoners with social care needs.

3.30 There had been some work to promote LGBT awareness to staff, such as poster displays and information leaflets. However, prisoners we spoke to were unaware of these, and at the time of the inspection we were told that no prisoners had disclosed that they were gay.

3.31 There were no transgender prisoners held at the time of the inspection, but there were policies and procedures to provide such support if the need arose.

Recommendation

3.32 **Professional telephone interpreters should be used where necessary, to support accurate and confidential communication.**

Faith and religion

3.33 The chaplaincy made sure that all the faiths practised by prisoners were represented. During the COVID-19 restrictions, the chaplaincy conducted weekly welfare visits to all prisoners, and faith resources, such as sermons and scriptures, were updated regularly and handed out to all prisoners. Some use was made of WayOut TV to communicate with prisoners and celebrate religious festivals, but this was not functional on all units.

3.34 In our survey, only 61% of respondents said that they could attend a religious service if they wanted to, which was lower than at the time of our last inspection (91%). The prison had restarted corporate worship shortly before the inspection, including the facilitation of Friday prayers in two rooms, to allow for social distancing. In our survey, 74% of respondents said that their religious beliefs were respected, similar to the proportion at the time of the last inspection. Similarly, despite Ramadan taking place during the difficult circumstances of COVID-19 restrictions, 83% of Muslim prisoners said that their religious beliefs were respected.

3.35 The chaplaincy had continued to provide good pastoral support during the pandemic. Use had been made of computer tablets to enable prisoners to view funerals.

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.

3.36 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 no breaches of the relevant regulations.

Strategy, clinical governance and partnerships

3.37 NHS England and Improvement commissioned health services, which were delivered by Spectrum Community Health CIC ('Spectrum') and a range of subcontracted agencies. Regular local delivery board and clinical governance meetings were informing service delivery, but health care managers were unaware of a current, up-to-date health needs analysis. Health care leaders were driving improvement through an integrated health action plan.

3.38 Health services, with advice and guidance from Public Health England, had responded diligently and creatively to the COVID-19 pandemic and had maintained the delivery of key services throughout, as well as managing two outbreaks. (A third outbreak was declared during the inspection.) All health and allied health services had now resumed in the prison.

3.39 Prisoners we spoke to were positive about health services, and 75% of respondents to our survey said that the overall quality of the health care provision was good. The number of health care complaints was low and the responses we looked at addressed the issue raised and offered an apology where appropriate. The separate health complaints system was well advertised in the health care department and on all the wings.

3.40 Patient feedback was collected regularly and discussed at staff meetings. Impressively, health care staff spoke to all prisoners who had been subject to the use of force, to gather their views on the incident and their aftercare. Health care leaders had good oversight of key risks and these were reviewed regularly.

3.41 Staff across all services now had access to regular management and clinical supervision, and most staff we spoke to felt supported and valued.

3.42 Clinical rooms in the health care department and on the wings generally met infection control standards and were clean and well ordered. However, the clinical room on B wing was unfit for use because of substantial water damage from the roof. We observed poor hand hygiene practice by some clinical staff.

3.43 Clinical records we looked at were of a good standard and all of the interactions we observed between health staff and prisoners were compassionate and caring.

3.44 Mandatory training compliance was excellent across all services, and opportunities for specialised and advanced training were actively promoted and encouraged.

3.45 Regularly checked and strategically placed emergency equipment was available and complied with national guidelines. Health care staff we spoke to were confident in their roles in an emergency, although some

custody staff we spoke to were unsure of the location of emergency equipment.

Promoting health and well-being

3.46 While an overarching local health promotion strategy remained under development, a range of promotional material was visible across the prison, including for dietary support, educational events and social activities.

3.47 Health promotion followed the national programme, facilitated through the health care team and well-trained health care peer workers on every wing. Activities included campaigns to support weight management, smoking cessation, diabetes awareness and 'heart start', whereby prisoners were offered training in basic life support.

3.48 Clinical records indicated that health screening programmes, including national blood-borne virus and HIV, were in place. An appropriate range of vaccines was available, with a 100% uptake in the hepatitis A vaccination by eligible prisoners. Weekend vaccination clinics were provided to improve vaccination take-up and wait times arising from the COVID-19 vaccination programme.

3.49 Administration of COVID-19 vaccines was in line with the national programme, with 100% of prisoners being offered the vaccine. However, uptake had been low and a targeted initiative to address patient concerns had been provided, with support from health care peer workers.

3.50 Sexual health services were provided, and condom availability was well advertised across the prison.

Primary care and inpatient services

3.51 Primary health care provision was delivered by a small, stable team and their patient care was excellent. There was an appropriate range of primary care services, including podiatry, optometry and physiotherapy clinics. The nursing team provided daily clinics, including triage, supported by GPs from a local practice, who provided three planned sessions a week and a flexible service at other times.

3.52 Registered nurses carried out an initial health screening for all prisoners on the induction wing on the day of their arrival and made sure that they had swift access to specialist follow-up services. Secondary health assessments took place within seven days of arrival.

3.53 The primary care appointments system was effective in ensuring access to services. Waiting times were good, and any delays to access because of pandemic restrictions were addressed actively. In our survey, 81% of respondents said that it was very or quite easy to see a nurse, and 64% to see the GP.

3.54 Prisoners with long-term conditions were managed well by nurses, who liaised with GPs and referred prisoners for specialist support when it

was needed. Prisoners had individualised care plans and were involved in their care planning.

3.55 There were appropriate arrangements for out-of-hours care, and access to other secondary health appointments was well managed. Hospital appointments were rarely cancelled by the prison, and the health care team contributed to prisoners' individual risk assessments, to make sure that security measures were proportionate.

3.56 Primary care discharge was well planned. Patients were reviewed in a discharge clinic, to make sure that they were registered with a GP and that information was shared appropriately. All prisoners needing medication on release were given seven days' supply or a prescription for controlled drugs, if appropriate.

Social care

3.57 A comprehensive memorandum of understanding for social care was about to be implemented in north-east prisons, to update current arrangements with relevant local authorities. Durham County Council (DCC) worked closely with the prison and Spectrum to ensure the delivery of social care, which was innovative and impressive.

3.58 Screening by Spectrum 'trusted' assessors identified social care needs promptly. The new memorandum of understanding would enable the establishment of a small DCC equipment store at the establishment, to facilitate rapid responses to more common needs. Following referral, DCC assessed social care needs formally and identified those prisoners meeting the threshold for funding a social care package (see Glossary of terms).

3.59 It was uncommon for prisoners at Deerbolt to need social care, although there were four at the time of the inspection. Personalised care plans were on SystmOne (the electronic clinical record) and were designed to enable a return to self-care while recovering from physical and mental health problems. One prisoner we spoke to expressed satisfaction with his care, which was delivered by health care assistants. A regional project had started at HMP Durham to prepare peer support orderlies for a variety of roles in north-east prisons, including providing support with daily living activities.

3.60 DCC and the north-east local authorities were engaged in a promising project to create 'reciprocal agreements' to enable continuing social care for those requiring it on release, as prison release was a known challenge in maintaining the pathway of care.

Mental health care

3.61 Since the last inspection, mental health services had expanded and now provided support seven days a week, including access to a counsellor. The team consisted of an impressive range of disciplines, including mental health nurses, associate nurses, psychology staff,

learning disability nurses, a speech and language therapist and a psychiatrist who specialised in neurodevelopmental assessments.

3.62 At the time of the inspection, 98 prisoners were being supported by the mental health team, and care and treatment were aligned with the evidence-based, stepped-care model of service delivery. There was no waiting list to see the psychiatrist, and two non-medical prescribers were available to prisoners.

3.63 Care plans we sampled were patient centred and reviewed regularly, and prisoners we spoke to valued the support of the team. Custody staff were positive about the mental health team's support and responsiveness.

3.64 All referrals were screened clinically, with urgent cases being seen on the same day, and mental health staff attended all initial assessment, care in custody and teamwork (ACCT) case management reviews.

3.65 Supervision arrangements were well embedded and staff we spoke to valued the monthly reflective practice session facilitated by the psychologist. Communication and joint working were being hampered by the lack of an appropriate workspace, but there were advanced plans to relocate to a more suitable environment.

3.66 The mental health team was actively part of the Royal College of Psychiatrists Quality Network in prison mental health, and the service was meeting the required standards.

3.67 As a result of COVID-19 restrictions, no custody staff training could be facilitated by the mental health team, but there were plans to deliver this again once restrictions allowed for groups to take place.

3.68 There had been three transfers to secure mental health inpatient units under the Mental Health Act in the previous 12 months, none of which had been transferred within the newly published NHS guidelines. While all three prisoners had been assessed within the initial 14-day guideline, they had subsequently waited 37, 90 and 167 days, respectively, for a bed, which was unacceptable (see key concern and recommendation 1.45).

Substance use treatment

3.69 Spectrum delivered clinical management of drug and alcohol treatment and subcontracted Humankind (a national charity) to provide the drug and alcohol recovery team (DART). Health care and DART staff worked in an integrated way to provide strong governance, and both worked collaboratively with the prison to implement the recently drawn-up substance recovery policy.

3.70 There were sufficient suitably trained, supervised and well-led DART recovery coordinators to offer psychosocial care and support, with an average of 90–100 service users on the caseload.

3.71 Commendably, the DART had maintained services throughout the COVID-19 restrictions, on a one-to-one basis. Group work had been suspended during the restrictions, but Humankind was geared up to start delivery when permitted. Recovery workers attended the wings to see service users, although they expressed frustrations that appointments were too often lost because of regime and allocations challenges and the availability of suitable rooms (see key concern and recommendation 1.46).

3.72 The DART had recently reintroduced induction sessions for new prisoners, which had been halted because of COVID-19. There was an open referral system, and prisoners held in segregation who were subject to adjudication because of being under the influence of illicit substances or following a positive mandatory drug test were also referred.

3.73 Assessments were completed within target times, and usually within a working day. Treatments were modular and tailored to the needs and concentration spans of service users. The DART's electronic treatment record contained care plans and detailed notes, but did not communicate with SystmOne, which was unavailable in the DART offices. This led to inefficient administrative practices as information had to be conveyed by hand to the health centre for inputting onto SystmOne (see key concern and recommendation 1.46).

3.74 Modules of tailored care and support were available to service users, with good-quality in-cell motivational workbooks on an extensive range of topics, including the risks of cannabis, 'spice' (a psychoactive substance) and tradable drug taking. The DART family worker encouraged essential links with families, in association with the offender management unit. Work to support prisoners with complex mental health and substance misuse problems was particularly good. However, the respective teams agreed that their work would be more efficient if they were co-located, which the prison, to date, had been unable to expedite (see key concern and recommendation 1.46).

3.75 In our survey, 75% of respondents said that they had been helped with drug and alcohol problems at the establishment, and service users spoke favourably of the support they had received.

3.76 Spectrum GPs and nurse prescribers used evidence-based practices in the treatment of drug and alcohol abuse. Opiate substitution therapy was available, but the need was infrequent, with no prisoners on this at the time of the inspection.

3.77 Peer workers were in the process of being recruited and it was planned for them to co-facilitate induction and therapy groups, following training. Links had been established with community Alcoholics Anonymous and Narcotics Anonymous groups to restart mutual aid work when permitted.

3.78 Humankind pre-release work included harm minimisation advice, training in the use of naloxone (an opiate reversal agent), with provision

of supplies to take home, and help with finding accommodation and engaging with community services. Humankind had just placed a 'Connecting Community' project worker at Deerbolt, whose role was to support service users with complex needs 'through-the-gate' and post-release, to get them established in the community.

Medicines optimisation and pharmacy services

3.79 Overall, the pharmacy delivered its services in a safe and effective manner. Prescriptions were issued on-site and sent electronically to a community pharmacy, and dispensed medicines were delivered back on the same day. Not-in-possession medicines were administered from the wings twice a day by a nurse and health care assistant, and we found custody officers' supervision of the medication hatch and health care staff's observation of compliance to be poor. Prisoners needing night-time medication were risk assessed and received a dose of medication in-possession.

3.80 Eighty-five per cent of medicines were supplied in-possession, and risk assessments and their outcome were available at the time of prescribing. Most medicines were supplied as patient-named items, with appropriate labelling and a dispensing audit trail. Items in the out-of-hours cupboard were pre-labelled by the supplying pharmacy; however, these should have been sourced from a supplier with an appropriate assembly licence. There was adequate provision to provide medication for prisoners on discharge and a core team was involved in discharge planning.

3.81 Transfer of medicines from the pharmacy room to the wings was secure and health care staff were accompanied by custody staff. Controlled drug management was generally good, but the controlled drug register was not maintained effectively, although the pharmacist planned to address this. There was regular auditing of prescribing, including the use of tradable medicines.

Recommendation

3.82 **Officers and health care staff should supervise the administration of medicines, to reduce the risk of bullying and diversion.**

Dental services and oral health

3.83 Prisoners were able to access advice and treatments equivalent to those provided by the NHS in the community. In our survey, 42% of respondents described the quality of the dental service as either very good or quite good.

3.84 Delays with accessing dental provision, as a result of the pandemic, were being addressed actively. There was a clear pathway for triage and those needing urgent care, and appointments for routine care had restarted. Every prisoner was offered preventative care and saw either an oral health educator, a dental therapist or the dentist, according to clinical need.

3.85 The dental suite met current infection prevention and control standards and equipment was maintained and serviced regularly.

Section 4 Purposeful activity

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

Time out of cell

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

4.1 Most prisoners spent 23 hours locked in their cells each day and had too little useful activity. The scheduled daily activity out of cell was half an hour in the fresh air, a shower and a 10-minute telephone call, with a few more minutes to collect food and prescribed medication. A few prisoners were employed in essential work activities in workshops or on the residential wings. Most of this work was part time, which shared out the opportunity to be out of cell. A larger number of prisoners were engaged in in-cell education, which consisted of workbooks marked by teachers. Short individual sessions with teachers were available to support progress with these workbooks (see key concern and recommendation 1.47).

4.2 During our roll checks, we found 55% of prisoners locked in their cells. A quarter were engaged in paid work outside their cells. The remaining prisoners were having their showers, telephone calls, gym or time in the fresh air. Prisoners were unlocked for these activities with others from their landing, in groups of up to nine at a time. Mixing across landings for showers, telephone calls, time outside and gym was not allowed. It was not clear why, as time progressed, group sizes had not been increased gradually, to improve time out of cell for all prisoners (see key concern and recommendation 1.47).

4.3 Prisoners were aware of the relaxing of restrictions in the community and were frustrated by the slow pace of change in the prison. Some told us that they were grateful that we had asked to speak to them, as it got them out of their cells for a few minutes. In our survey, when asked what they would like to see changed at the prison, some commented on the regime and its impact – for example:

> '*More than 30 mins out a day as it is bad for everybody's mental health.*' (See key concern and recommendation 1.47.)

4.4 When we went to see prisoners, they were either bored in their cells or asleep, as a result of the lack of meaningful activity. For many, custody at this time was neither purposeful nor rehabilitative. There was no indoor association provided, which limited the availability of social activities. One individual wrote a survey comment that illustrated the

length of time that prisoners had been without normal social interaction with their peers:

> '*To bring association back, even for half hour a day, landing by landing, really think no-one would risk losing it as not having it for a year and a half*.'

We had concerns about the impact that this extended period spent without regular social interaction could have on the well-being of young adults with long prison sentences, whose access to family and other significant people in the community was often restricted to one 10-minute telephone conversation each day (see paragraph 5.4, and key concerns and recommendations 1.47 and 1.49).

4.5 The library, run by Durham County Council, was a good resource. A system for obtaining books had been operated by prison staff earlier in the pandemic, when library staff had not been able to work in the prison. Librarians had been managing this since their return in September 2020, as prisoners were still not able to attend the library in person. Prisoners received weekly order forms, along with updates on new stock and other resources available, which included Prison Service Instructions, in-cell workouts, driving test theory, audiobooks and foreign language books. Over three times as many items had been borrowed in May 2021 than in September 2020.

4.6 Gym courses had had to be suspended during the pandemic. PE instructors had been offering outdoor sessions since July 2020 while the indoor gym was closed. The indoor facilities had been upgraded during the pandemic and had been open or closed to prisoners, in line with community restrictions. During the inspection, PE instructors offered recreational PE in the gym daily. As with other activities, group sizes were limited to nine at a time. Most prisoners had access to at least one 45-minute session each week and some had two. These sessions were appreciated by prisoners, but some had had to be cancelled because of staffing issues, and there was no weekend provision.

Education, skills and work activities

Ofsted

This part of the report is written by Ofsted inspectors. From May 2021 Ofsted began carrying out progress monitoring visits to prisons to assess the progress that leaders and managers were making towards reinstating a full education, skills and work curriculum. The findings and recommendations arising from their visit are set out below.

4.7 Ofsted assessed that leaders were making reasonable progress towards ensuring that staff teach a full curriculum and provide support to meet prisoners' needs, including the provision of remote learning.

4.8 Leaders and managers had made sure that most prisoners were able to access some form of education, skills or work. Managers had a clear strategy to reintroduce a full curriculum, which included new provision such as barbering, music and furniture restoration. Managers' plans recognised that the quality assurance of learning required improvement to raise standards for all prisoners.

4.9 The prison had made good use of in-cell learning packs and small group teaching in workshops to promote effectively prisoners' development. This was supplemented by a small range of relevant programmes available on prisoners' in-cell television. Prison managers had chosen to offer a few wing-based learning sessions, but no classroom activity was available yet. This hindered substantially the development of those prisoners who learnt best through direct teacher contact. Teachers gave appropriate support to the few prisoners studying on Open University courses (see key concern and recommendation 1.48).

4.10 A small number of prisoners attended industry workshops, which had remained open throughout the pandemic. They mostly provided purposeful activities that helped prisoners develop the employment-related skills needed for successful resettlement on release. Where relevant, these prisoners completed in-cell learning packs to refresh their existing competence, particularly in English and mathematics.

4.11 Prisoners in industry workshops took pride in their completed work and developed a good appreciation of ecological issues and how their work could affect the environment. Those in bicycle repair and maintenance, cleaning and waste management areas were particularly adept at explaining how they would apply their learning on release. At work and in workshops, we observed prisoners using safe working practices.

4.12 Prisoners had access to learning materials that were generally of a high standard. Managers had made good use of comments from prisoners to improve the quality of the packs.

4.13 Teachers generally provided prisoners with useful written and verbal feedback to help them to avoid repeating mistakes and/or to progress rapidly. Where relevant, prisoners benefited from recognition of partial course completion. However, a minority of learning packs were not always planned logically enough to help prisoners build their competences. Throughout education, skills and work, learning packs often failed to challenge the more able prisoners sufficiently.

4.14 Prisoners did not have routine access to the appropriate information technology, virtual campus or in-cell telephony needed to allow them to make swifter progress. For example, in digital skills classes the reinforcement of prisoners' learning through the linking of theory to its practical application was not possible. Prisoners were able to access

relevant learning materials, such as calculators and dictionaries, to support independent learning.

4.15 Induction activities were not consistently effective. Managers placed an over-reliance on prisoners reading information sent to their cells, with little rigorous checking of their understanding. Prisoners often failed to return requested information or did so in an incomplete form. Managers' oversight of a prisoner's starting points was therefore not sufficiently comprehensive. Staff did not always have the most current information needed to inform successful planning of prisoners' learning.

4.16 Current information, advice and guidance arrangements were relatively new and not fully effective. COVID-19 restrictions and staff absence had delayed the review of all prisoners' career aspirations. A few prisoners were therefore enrolled on education courses that were poorly related to the achievement of their goals following release. It was too early to evaluate the recently implemented improvements to address the deficit in the quality and quantity of information, advice and guidance that prisoners received.

4.17 Leaders and managers had appropriately prioritised the participation in remote learning of prisoners with additional learning needs and/or disabilities, or those who needed to improve their English and/or mathematics skills. Prisoners who were struggling with independent learning or had fallen behind during the restricted regime were also considered a priority.

4.18 Suitably qualified staff identified and implemented well-considered strategies that helped prisoners to overcome their barriers to learning. This included prisoners' use of resources such as magnifying sheets and coloured overlays. Staff made sure that such prisoners received more intensive individual support and/or help on the accommodation wings.

4.19 Managers monitored the progress made by prisoners in education, skills or work closely and made sure that they achieved at an increased rate. For example, those with English as a second language developed both their writing and comprehension skills at a good pace. Managers acknowledged that the number of qualified prison mentors was not high enough to support prisoners' learning adequately.

Recommendations

4.20 **All prisoners should participate in an effective induction process that includes the comprehensive collection of their starting points. All staff should use this information to plan and review prisoners' participation in relevant education, skills or work that meets their needs fully.**

4.21 **Leaders and managers should introduce and implement suitable information, advice and guidance, and arrangements to make sure that all prisoners make informed and realistic career decisions.**

Section 5 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.

5.1 It was positive that the governor had recommissioned a full-time family support worker previously provided by the community rehabilitation company (CRC). The service was due to restart shortly. The family support worker had provided one-to-one support across a wide range of family matters, offered advocacy with any family legal matters for prisoners who needed it, and linked with resettlement work. This worker also consulted families, holding focus groups and conducting a yearly visitors survey in conjunction with the visitors centre.

5.2 Social visits had only recently restarted, and the number of available tables had been restricted from 40 to nine to ensure social distancing. Uptake of the now limited visits spaces was, not surprisingly, good. Storybook Dads (whereby prisoners record stories for their children) also took place. Stories were normally recorded and sent out but, innovatively, prisoners could also read their children a story during a secure video call (see Glossary of terms) and additional visits were provided for this.

5.3 Secure video calls were popular, with between 150 and 200 taking place in the visits room each month. Leaders had thought about families' needs and arranged for these visits to take place on weekday evenings, when families were more likely to be available.

5.4 Two wings now had in-cell telephones, but prisoners located on the other wings had only 10 minutes' access to the telephones per day and no time in the evenings at all, which impeded family contact for many prisoners (see key concern and recommendation 1.49).

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.

5.5 At our previous inspection, just over half of the prisoners had been assessed as presenting a high or very high risk of harm to others; at this inspection, 68% were assessed at this level. Sixty-two per cent of prisoners were serving sentences of over four years, a small increase from 57% at the time of the last inspection.

5.6 Oversight of the offender management unit and reducing reoffending function was good. Leaders communicated well with staff and prisoners, and clear priorities were in place. The Offender Management in Custody model (see Glossary of terms) had been fully implemented across the department and this was complemented by a good reducing reoffending strategy which covered each of the reoffending pathways. This strategy was informed by regular consultation with prisoners, and the senior probation officer who was based on-site had also recently conducted a needs analysis from offender assessment system (OASys) assessments.

5.7 Reducing reoffending meetings took place monthly. These concentrated on the reoffending pathways and the action plan, Meetings were well attended, actions were monitored and completed quickly, and it was clear that leaders made sure that any outstanding actions were addressed as a priority.

5.8 In our survey, only 58% of respondents said that they had a custody plan. Of these, 85% said that they knew what they needed to do to achieve their targets, but only 39% that someone was helping them to achieve them. However, we found every prisoner had an assessment of their needs and risk, and a sentence plan. Plans were reviewed routinely every two years, which fell short of our expectation that this should take place annually. However, reviews also took place following any change in circumstances; these were completed quickly, which meant that more than two-thirds of prisoners had been reviewed within the last 12 months. The sentence plans that we reviewed were mostly of high quality. Links between POMs and their counterparts in the community were good, especially for prisoners assessed as presenting a high or very high risk to the public who were due to be released.

5.9 Contact between POMs and prisoners was driven mainly by time-bound processes such as release and OASys assessments, and interactions were face to face. POMs had informal contact on an infrequent basis, and only a limited amount of one-to-one work to drive progression took place.

5.10 There was little work done for life-sentenced prisoners specifically. However, this had been identified through the needs analysis, and lifer groups run by the offender management unit had started recently. Three lifer peer mentors had been recruited from the lifer population and were ready to start working as soon as the prison relaxed the regime restrictions.

5.11 Home detention curfew (HDC) was well managed, with very few prisoners released beyond their eligibility date, and most of these were due to delays in probation staff being able to approve an accommodation address before release. The Bail Accommodation Support Service provided housing when there was no alternative accommodation available, and delivered a timely and effective service.

Public protection

5.12 Public protection arrangements were well managed and there was good oversight, to make sure that the handover and sharing of information to community offender managers were systematic. The establishment did not hold prisoners convicted of sexual offences, but had a large number who were subject to multi-agency public protection arrangements (MAPPA).

5.13 In the previous 12 months, the establishment had managed 64 prisoners who were subject to MAPPA. MAPPA management levels were always confirmed with the probation service six months before release.

5.14 High-risk prisoners due for release were considered initially by the senior probation officer six to eight months before release, and were discussed at the interdepartmental risk management team meeting (IRMT) at least three months before release. The leadership team had put considerable effort into making sure that these meetings were well attended; impressively, community offender managers also dialled in, which resulted in effective risk management and information sharing. Any actions generated from these meetings were monitored closely and cases were brought back early if the team felt that there had not been suitable progress.

5.15 Very complex cases were discussed at stand-alone meetings and given the level of attention that they needed. These meetings, along with the IRMT meeting, had continued throughout the pandemic. All high-risk prisoners had their accommodation needs addressed by the POM, who linked directly with the community offender manager; this was a good and effective arrangement.

Categorisation and transfers

5.16 The prison followed the new digital categorisation process and all initial categorisations and reviews were completed on time. Prisoners arrived initially categorised as 'YOI closed' and were given a full adult male category when they turned 21. There were few delays for prisoners moving to open conditions or progressing to an adult prison, but those

who were under 21 and wanted to transfer closer to home or needed to move to progress with their sentence plan could experience considerable delays as POMs found it difficult to obtain places in suitable prisons.

5.17 A pilot scheme between Deerbolt and HMP/YOI Wetherby aimed to improve transitions from the children's estate. Children were seen via teleconference at least twice in the month before arriving. They were told what to expect on arrival and their concerns were discussed. Some areas included in the scheme, such as an extended handover by mental health staff for children they were engaged with, introduced a welcome improvement over the current arrangements.

Interventions

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

5.18 Interventions had stopped at the start of the pandemic. The accredited thinking skills programme (TSP) had now restarted, with one course already completed and another under way. Resolve, another accredited programme, tackling violence and aggression, was also due to restart.

5.19 The senior probation officer's needs analysis (see also paragraph 5.6) had highlighted the need for another accredited programme, Kaizen, which also tackled violence but was more intensive; the governor had supported this and it was hoped that it would start soon.

5.20 Leaders had planned accredited programme delivery so that prisoners with the greatest need were prioritised and that the backlog caused by the pandemic restrictions would be cleared before the release of those with shorter sentences. As a result of the restrictions, some prisoners had been discharged without completing programmes that were on their sentence plan, but leaders were unable to tell us how many.

5.21 Several non-accredited programmes had been delivered throughout the pandemic, including Choices for Change, which helped prisoners with maturity issues, and Timewise, which helped prisoners subject to a challenge, support and intervention plan (see paragraph 2.9) who needed help to reduce their use of violence.

5.22 There was a care leavers support worker, who provided excellent one-to-one bespoke support for prisoners who had recently left local authority care. At the time of the inspection, there were 86 prisoners who had been identified as needing this service, and each was seen individually to assess their need. Prisoners spoke highly of this worker and the work they carried out, which included advocacy with the local authority, resettlement planning and the provision of support on release, including with housing and forming links in the community. It was pleasing that the governor appreciated the value of this work and had resourced and recommissioned the service recently.

5.23 Before the pandemic, Paving the Way, a programme designed to help care leavers, had also been delivered and there were plans to restart this soon, along with the reintroduction of peer support workers.

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.

5.24 Despite still not being resourced as a resettlement prison, the number of discharges into the community had increased since the previous inspection, and from a much smaller number of prisoners, from 178 to 221 releases over the last 12 months.

5.25 The transition from the CRC to the probation service (PS) had not affected 'through-the-gate' (TTG) services at the establishment. Staff from the CRC provider had moved across to the PS and were continuing to deliver a good service.

5.26 The TTG staff member saw every prisoner on arrival and addressed their debt needs. Twelve weeks before release, they saw prisoners again and completed a resettlement plan.

5.27 If prisoners did not have a bank account, the TTG worker arranged one for them. Those being released on HDC also benefited from this service; 31 bank accounts had been opened in the last six months.

5.28 The TTG worker arranged housing and liaised with the community offender manager, to make sure that the address was suitable. If stable accommodation could not be found, prisoners were referred to the local authority for emergency accommodation on the day of release. From 103 releases so far in 2021, 17 had been to emergency accommodation, which could be destabilising for the prisoners concerned.

5.29 There had been only nine education, training or employment outcomes for prisoners on release in 2021, as the service had stopped throughout the pandemic. The education provider did not link with the POM or feed any information back to the resettlement plan, which meant that the prison and probation service may not have been aware of all aspects of a prisoner's release arrangements.

Section 6 Recommendations in this report

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

Key concerns and recommendations

6.1 Key concern (1.38): There were few meaningful incentives to motivate positive behaviour among young adult prisoners. The regime offered few opportunities for progress to be supported or recognised among those who engaged constructively with their sentence plan or the wider custodial experience. The existing and limited incentives scheme was not applied equitably.

Key recommendation: Managers should review the prison's approach to incentives in all aspects of prison life. Rewards and incentives that are meaningful to prisoners and which recognise and support those who engage with the regime and behave well should be introduced. (To the governor)

6.2 Key concern (1.39): Processes to manage victims and perpetrators of violence (challenge, support and intervention plans) were in disarray. Only serious incidents of violence were investigated. Subsequent plans to manage victim and perpetrators lacked detail, wing staff were unsure of who was subject to monitoring and why, and there was no managerial oversight of the process, including reviews. As a result, some prisoners were locked up for several weeks without meaningful human contact, welfare checks or any indication as to when the restrictions would end. There was no system to resolve conflicts between prisoners swiftly, which meant that the default response was to keep prisoners apart, rather than help them resolve their issues.

Key recommendation: Oversight of violence reduction measures should make sure that all incidents of violence are investigated swiftly and that victims and perpetrators are challenged and supported appropriately. (To the governor)

6.3 Key concern (1.40): Despite some improvements in governance, weaknesses in use of force practice were not always identified by the prison or referred subsequently to the governor for further investigation. Due to poor recording and accountability, some footage of incidents from body-worn cameras was now unavailable. Special accommodation had been used six times in the last six months, and prison records did not demonstrate that there had been adequate justification or that it had been necessarily used as a last resort.

Key recommendation: Use of force and use of special accommodation should be more accountable with concerning incidents promptly and properly investigated and opportunities for learning and improvement usefully exploited. (To the governor)

6.4 Key concern (1.41): The segregation unit was bleak. Cells, showers and exercise yards were in poor condition and there was no in-cell electricity. It required urgent refurbishment. Apart from a basic regime entitlement of a daily shower, telephone call and half an hour's outdoor exercise, there was little to engage, stimulate or encourage positive behaviour. Multi-unlock staffing levels were routine, without documented authority or daily reviews to check if they remained appropriate.

Key recommendation: The purpose of segregation, and the regime and environment that support it, should be to prioritise meeting the specific needs of individuals, provide support to improve their behaviour and develop an approach that encourages and incentivises their re-engagement with the prison regime. (To the governor)

6.5 Key concern (1.42): The key work scheme was not functioning at the time of the inspection. This lack of regular meaningful interaction was of concern, given the potential impact of continuing restrictions on prisoners' well-being and progression.

Key recommendation: Managers should make sure that every prisoner has regular contact with a key worker who can address their welfare needs and progression goals. (To the governor)

6.6 Key concern (1.43): Consultation arrangements were poor and the resolution of issues was very slow. Prisoners had become disengaged from the consultative process as they felt that they were not taken seriously, and that the prison failed to act on the concerns they raised.

Key recommendation: There should be ongoing, meaningful consultation with prisoners, with their issues and concerns addressed and resolved in an accountable way. (To the governor)

6.7 Key concern (1.44): There had been no consultation with prisoners in protected groups, which undermined the DEMT's effectiveness, and there was little work with prisoners to promote protected characteristic groups. Black and minority ethnic prisoners reported more negatively than their counterparts in our survey. There was little analysis of data relating to the treatment and experience of those with protected characteristics. Actions from the DEMT meeting often took too long to resolve..

Key recommendation: There should be consultation with prisoners in protected groups, and detailed analysis of the data relating to the treatment and experience of these prisoners. This should be used to identify and address any differences in treatment leading to more equitable outcomes. (To the governor)

6.8 Key concern (1.45): Prisoners needing a transfer to hospital under the Mental Health Act waited far too long for a bed.

Key recommendation: The local delivery board, in conjunction with NHS England and Improvement, should make sure that transfers to secure mental health inpatient units under the Mental Health Act take place within the national timescale of 28 days. (To the governor)

6.9 Key concern (1.46): Continuing integration of the work of the substance misuse team with physical health, clinical management and mental health teams and the efficiency of joint care delivery were being hampered by lack of access to SystmOne, the inability to co-locate mental health and drug and alcohol recovery teams, and lost appointments due to regime and allocations challenges.

Key recommendation: Challenges to the continuing integration of the work of Spectrum, Tees, Esk and Wear Valleys, and Humankind staff should be resolved by the local delivery board. (To the governor)

6.10 Key concern (1.47): Many prisoners spent up to 23 hours in their cells each day with too little to do. Progress to improve the poor regime had been slow. We were concerned about the impact on the well-being and progression of young prisoners, who had limited opportunities to talk to staff, socialise with peers or maintain their relationships with loved ones; were not kept physically or mentally active; and spent only 30 minutes each day in the fresh air.

Key recommendation: Time out of cell and access to activity should be improved and increased. (To the governor)

6.11 Key concern (1.48): At the time of the inspection, no prisoners could access group lessons, either on the wing or in classrooms. This hindered substantially the development of those prisoners who learnt best through direct teacher contact.

Key recommendation: Leaders and managers should expand the learning offer by introducing wing- and classroom-based learning sessions as soon as is practically possible. They should provide prisoners with access to relevant information technology resources and enough mentoring support to help them progress. (To the governor)

6.12 Key concern (1.49): Most prisoners had limited access to the telephone, with only 10 minutes allowed each day. There was no availability on some wings for prisoners to make telephone calls in the evenings, when their families were most accessible.

Key recommendation: All prisoners should have access to the telephone at least once a day, for a duration and at a time that supports meaningful family contact. (To the governor)

Recommendations

6.13 Recommendation (3.32): Professional telephone interpreters should be used where necessary, to support accurate and confidential communication. (To the governor)

6.14 Recommendation (3.82): Officers and health care staff should supervise the administration of medicines, to reduce the risk of bullying and diversion. (To the governor)

6.15 Recommendation (4.20): All prisoners should participate in an effective induction process that includes the comprehensive collection of their starting points. All staff should use this information to plan and review prisoners' participation in relevant education, skills or work that meets their needs fully. (To the governor)

6.16 Recommendation (4.21): Leaders and managers should introduce and implement suitable information, advice and guidance, and arrangements to make sure that all prisoners make informed and realistic career decisions. (To the governor)

Section 7 Progress on recommendations from the last full inspection

Recommendations from the last full inspection

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

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2018, prisoners' experience during their early days was reasonably good. Levels of violence remained relatively low. The prison's approach to managing behaviour focused on sanctions and offered prisoners whose behaviour was good few incentives. While adjudications, force and segregation were used less frequently than elsewhere, governance was poor. Prisoners had concerns about the excessive use of force and there were three ongoing investigations. Security was generally proportionate, but the prison did not monitor the effectiveness of measures for combating drug trafficking. The number of incidents of self-harm was relatively low and care for prisoners on assessment, care in custody and teamwork (ACCT) case management documents for prisoners at risk of suicide or self-harm was reasonably good. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

Managers should ensure that all aspects of discipline are effectively monitored on a regular basis. They should also ensure CCTV footage of incidents involving force is reviewed regularly and Staff statements are submitted promptly to confirm that force is used proportionately and is warranted. (S37)
Achieved

Recommendations

The prison should have onsite video link facilities so prisoners do not have to make unnecessary visits to court and can contact legal and professional visitors about ongoing court cases and preparations for release. (1.8)
Achieved

There should be specific arrangements to support the transition of young people from the juvenile estate into the prison. (1.9)
Achieved

A review of the induction programme should be undertaken with prisoners' involvement to ensure it meets their needs and keeps new arrivals fully occupied. (1.10)
Not achieved

The IEP scheme should be meaningful and provide achievable rewards that encourage positive behaviour. (1.22)
Not achieved

The prison should investigate and address the reasons for prisoners' reluctance to report victimisation by other prisoners and staff. (1.23)
Not achieved

Prisoners involved in bullying should be challenged about their behaviour and set realistic targets, appropriately linked to their behaviour, which should be reviewed to measure any improvements. (1.24)
Not achieved

An adjudication standardisation meeting should be introduced to improve how adjudications are governed. It should carry out effective quality assurance to ensure all aspects, including a prisoner's defence, are explored appropriately and effectively. (1.30)
Achieved

Reintegration plans should be detailed enough for both staff and prisoners to understand. (1.41)
Not achieved

Prisoners should not be moved from the segregation unit to the first night centre unless there are exceptional circumstances. (1.42)
Achieved

Drug strategy meetings should take place regularly and a prison-wide action plan should be established and monitored. (1.51)
Achieved

Robust procedural security measures, such as photocopying mail, should be supported by an evidence-based strategy, which should ensure they are monitored and evaluated. (1.52)
Achieved

Closed visits should only be imposed for reasons directly relating to visits. (1.53)
Achieved

Prisoners subject to ACCT management should have access to a full daily regime including, where appropriate, access to in-cell work. (1.60)
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2018, we observed good, respectful interactions between most staff and prisoners. The prison was not overcrowded and living conditions remained reasonably good despite a significant backlog of maintenance work. The food met dietary requirements but appeared unappetising. The range of items sold by the prison shop had increased and now included fresh fruit. Applications and complaints were not managed well and prisoners experienced problems accessing legal advice. Work to support equality and diversity was reasonably good and covered most groups. Prisoners had good access to an appropriate range of health care services that met their needs. Outcomes for prisoners were reasonably good against this healthy prison test.

Recommendations

The prison and HM Prison and Probation Service should ensure that all outstanding work and redecoration are completed without further delay. (2.12)
Not achieved

Prisoners should be consulted regularly about the food, and their dissatisfaction should be investigated and addressed. (2.20)
Achieved

All statutory food hygiene requirements should be met. (2.21)
Not achieved

Prisoners should not be charged a handling fee for catalogue orders. (2.22)
Not achieved

The applications process should be monitored and quality assured. Responses to applications and complaints should be timely and polite and replies to complaints should provide a full answer. (2.31)
Not achieved

Solicitors should be able to book legal visits promptly and legal correspondence should be delivered without delay. Privileged legal mail should only be opened in the presence of the prisoner, prisoners' perceptions in our survey relating to privileged mail should be investigated. (2.32)
Not achieved

Discrimination incidents should be investigated within the prescribed timescales. (2.38)
Achieved

Prison managers should explore the reasons for black and minority ethnic prisoners' negative perceptions in our survey. (2.43)
Not achieved

The foreign national officer should be given sufficient time to carry out their duties. (2.44)
Not achieved

Washing facilities should be provided for Muslim worshippers. (2.49)
Achieved

Prisoners on the basic regime should not have to choose between attending religious services and association. (2.50)
Achieved

Health care practitioners should receive regular, documented clinical supervision. (2.62)
Achieved

Emergency equipment, including appropriate medication, should be readily accessible to those responding to medical emergencies. (2.63)
Achieved

There should be an integrated, prison-wide, strategic approach to promoting health and well-being, including well-advertised condom provision. (2.66)
Achieved

Prisoners should have prompt access to counselling services. (2.80)
Achieved

Prisoners requiring treatment in hospital under the Mental Health Act should be transferred in line with the NHS's guidelines on timescales. (2.81)
Not achieved

The service should integrate peer mentors and incorporate more support from community groups. (2.88)
Achieved

Officers should supervise the administration of medicines to reduce the risk of bullying and diversion and ensure prisoners can communicate with health care staff in confidence. (2.97)
Not achieved

Purposeful activity

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

At the last inspection, in 2018, the prison did not have enough activity spaces to occupy the population and we found a third of prisoners locked in their cells during the working day. This was a concern, given the establishment's role as a training prison for young men. The library and gym provided prisoners with a good service. Managers focused on improving the activities and had plans in place to achieve this. The new

Skills Academy showed promise. Teaching was variable and many prisoners did not make the progress they were capable of. Attendance and punctuality were reasonably good and most prisoners behaved well in education, training and work activities. The use of prisoner mentors had developed well. Too many learners did not achieve qualifications particularly those studying English and maths. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

Prison managers should increase the number and broaden the range of activity places to meet the needs of the prison population. (S38)
Not assessed at this inspection

Recommendations

All prisoners should have access to four evening association sessions a week. (3.11)
Not achieved

Exercise periods should last for one hour, and exercise yards should contain benches or recreational equipment. (3.12)
Not achieved

Novus managers should scrutinise performance data more effectively to pinpoint precise areas for improvement and take action accordingly. (3.22)
Not assessed at this inspection

Prison leaders should improve prisoners' resettlement arrangements in conjunction with external partners. (3.23)
Not assessed at this inspection

Leaders and managers should integrate English and maths into sessions effectively. (3.30)
Not assessed at this inspection

More prisoners should use portfolios to record and celebrate their progress. (3.31)
Not assessed at this inspection

Teachers should receive support to help them manage poor behaviour in class. (3.38)
Not assessed at this inspection

A greater range of accreditation opportunities and qualifications should be available for work activities. (3.42)
Not assessed at this inspection

Managers should improve course completion and retention rates to ensure prisoners achieve the qualifications they are capable of, particularly in functional skills. (3.43)
Not assessed at this inspection

Rehabilitation and release planning

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

At the last inspection, in 2018, support to help prisoners maintain or re-establish family ties was good, but the distance of the prison from many prisoners' homes prevented family and friends from visiting regularly. The strategic management of resettlement had deteriorated and little support was in place for prisoners who were released from Deerbolt. Offender management work in high-risk cases was generally good, but too variable in many other cases. Few prisoners could move to another prison to undertake offending behaviour programmes and were therefore released without having addressed their offending. Pre-release risk management planning needed to be more consistent. The community rehabilitation company (CRC) did not appear to be meeting the needs of the population and release planning or outcomes were not recorded. Offending behaviour courses were unavailable during the inspection. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

HM Prison and Probation Service should work with the prison to overcome staff shortages and either reinstate the delivery of accredited offending behaviour programmes or agree a strategy so prisoners can move to other prisons to participate in them. (S39)
Achieved

Recommendations

The number of places in BASS accommodation and approved premises should be increased to meet the rising demand created by the larger number of HDC releases. (4.20)
Achieved

Sanctions against those on the basic IEP level should not include restrictions on the meaningful time they can spend with family, carers and friends. (4.5)
Not achieved

Managers should investigate and resolve prisoners' dissatisfaction with the mail service. (4.6)
Not achieved

The prison should develop its approach to maintaining family ties to take account of the distance of the prison from many prisoners' homes. (4.7)
Achieved

The strategic management of reducing reoffending work should be improved. The prison should develop a strategy and action plan that is specific to the needs of its population, and a well-attended committee should oversee progress. (4.18)
Achieved

All prisoners should have regular and meaningful contact with their offender supervisor. Contact should focus on identifying prisoners' risks and unmet needs and supporting them to progress. (4.19)
Not achieved

The IDRMT should provide detailed oversight for all high risk of harm, including MAPPA level 1 cases in the last six months in custody to ensure robust risk management planning is undertaken and implemented. (4.26)
Achieved

The proportion of prisoners released from Deerbolt without sustainable and suitable accommodation should be monitored and the results should inform the accommodation service provided. (4.33)
Not achieved

The CRC should monitor delivery of the contract at Deerbolt more closely and report its findings to the prison so managers can determine how effective the provision is and whether the work is being completed as intended and adds value. (4.36)
No longer relevant

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 6 lists all recommendations made in the report. Section 7 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

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

Inspection team

This inspection was carried out by:

Martin Lomas	Deputy Chief Inspector
Angus Jones	Team leader
David Foot	Inspector
Esra Sari	Inspector
Angela Johnson	Inspector
Tamara Pattinson	Inspector
Donna Ward	Inspector
Becky Duffield	Researcher
Joe Simmonds	Researcher
Jed Waghorn	Researcher
Charlotte Betts	Researcher
Shaun Thomson	Lead health and social care inspector
Paul Tarbuck	Health and social care inspector
Peter Gibbs	Pharmacist
Chris Barnes	Pharmacist
Helen Lloyd	Care Quality Commission inspector
Dayni Johnson	Care Quality Commission inspector
Nigel Bragg	Ofsted inspector
Suzanne Wainwright	Ofsted inspector
Cath Jackson	Ofsted inspector

Appendix II Glossary of terms

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/

Adults at Risk in Immigration Detention
The policy, introduced in 2016, is intended to contribute to a reduction in the number of vulnerable people in detention, and in the length of their detention before removal.

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

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

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

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

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.

PAVA
PAVA (pelargonic acid vanillylamide) spray is classified as a prohibited weapon by section 5(1) (b) of the Firearms Act 1988.

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).

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

Secure video calls
A system commissioned by HM Prison and Probation Service (HMPPS). This system 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. For this report, these are:

Prison population profile

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

Prisoner survey methodology and results

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

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
England