Report on a scrutiny visit to

HMP Humber

by HM Chief Inspector of Prisons

27 October and 3–4 November 2020

Crown copyright 2020

This publication, excluding logos, is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/

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

Contents

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/

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 owing 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 a CSIP. Some prisons also use the CSIP framework to support victims of violence.

End of custody temporary release scheme
A national scheme through which risk-assessed prisoners who are within two months of their release date can be temporarily released from custody. See: https://www.gov.uk/government/publications/covid-19-prison-releases. This scheme was paused at the end of August 2020.

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.

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

Personal protective equipment (PPE)
Safety equipment including masks, aprons and gloves, worn by frontline workers during the COVID-19 pandemic.

Purple Visits
A secure video calling 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.

Reverse cohort unit (RCU)
Unit where newly arrived prisoners are held in quarantine for 14 days.

Shielding
Those who have health conditions that make them vulnerable to infection are held for at least 12 weeks in a shielding unit.

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

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

Telemedicine
The practice of caring for patients remotely when the provider and patient are not physically present with each other.

Introduction

HMP Humber is a large category C training prison in East Yorkshire. It is an amalgamation of the formerly privately run HMP Wolds (zone 1) and the old Everthorpe prison (zone 2). At the time of our scrutiny visit, the prison held 925 adult male prisoners, which was a slight reduction on the population held before the implementation of the COVID-19 restrictions. This meant that fewer prisoners were sharing small cells originally designed for one person, which helped in controlling the spread of the virus.

The senior management team had reacted quickly to minimise the spread of the COVID-19 virus following the announcement of the restrictions in prisons at the end of March 2020. There was an outbreak among staff in May, but this was handled well. Many prisoners we spoke to were positive about the steps taken throughout the last seven months to keep them safe, and at the time of our visit few staff had tested positive and no prisoners were currently positive.

Despite a clear desire and regular reminders to maintain social distancing, this was very difficult to achieve in some parts of the prison, particularly in zone 2, where corridors and landings were much narrower. Arrangements to keep new prisoners separate from others on the two reverse cohort units were proportionate and sensible, but the use of a shared exercise yard with prisoners from other wings presented an avoidable risk of the virus being transmitted.

Senior managers had planned and taken some important steps towards recovery. However, they were frustrated at the slow pace of recovery set out by national guidance from HM Prison and Probation Service (HMPPS), which gave little room for local autonomy. In addition, plans for further recovery were in doubt following the start of a second national lockdown in the community which would come into force on the day after our visit.

Many of the strategic meetings had been suspended early on in the restricted regime, which was understandable, given the need to focus on the imminent risk of the COVID-19 virus spreading within the prison. It was good to see that these had been reinstated, and most were providing important oversight again. However, the strategic meeting for equality and diversity needed to become more fully embedded and effective over the coming months. The senior management team recognised the need to improve the focus on equality and diversity across the prison.

Data before and during the restricted regime showed that the number of incidents of violence and self-harm had fallen considerably. The number of times that force had been used against prisoners had also reduced since the end of March, and the number of prisoners placed in the segregation unit was very low. In our survey, few prisoners said that they currently felt unsafe. Few felt bullied or victimised by other prisoners but about a third felt victimised by staff. The reasons for the latter perception were unclear.

The care for those at risk of self-harm was reasonable, but we were surprised to find that the formal Listener scheme had not been fully functioning since the end of March. The peer-led support groups known as Andy's Man Club had resumed in July and were very popular. Staff regularly undertook well-being checks on all prisoners, and the safer custody team, alongside the safety intervention meeting, provided good oversight of, and support to, the most vulnerable. The use of anti-ligature clothing for prisoners in crisis was unusually high, which we found concerning, and prisoners' negative perceptions of the care they received while in crisis needed to be explored.

Staff–prisoner interactions were positive, but the formal and structured key worker sessions had been suspended early on in the restricted regime. Consultation with prisoners was promoted by a peer-led scheme known as the 'Humber Pilot'. Living conditions were decent and clean. Prisoners had good access to essential items, and the regime was reliably delivered on the whole. The

complaints process was concerning, and we found some serious complaints that had not been adequately dealt with.

Health care staff had maintained core functions during the COVID-19 restrictions, including access to GPs and nurses, emergency dentistry, mental health services and substance misuse support. Some of the clinics and therapies curtailed during the restrictions had yet to restart, and the dental service had accumulated an extensive waiting list. There had been errors within medicines management that compromised prisoner safety.

The number of prisoners in some form of purposeful activity out of their cell had increased recently to about a quarter of the population. A few workshops had reopened with a reduced capacity, and safe systems of working and some education sessions were now taking place. However, for the majority not in an activity, they remained locked in the cell for 22.5 hours a day, and some of those we spoke to clearly described the detrimental impact this was having on their health and well-being.

Social visits had restarted but would be suspended again following the imminent further restrictions in the community. Video calling was available, but the uptake was low. In-cell telephones provided a huge benefit.

Before the pandemic and the introduction of the restricted regime, HMP Humber had had a clear focus on progression and rehabilitation. For a prison of this type, where prisoners are eager to progress, the loss of many of the rehabilitative tools was a huge frustration. The delivery of offending behaviour programmes had restarted, albeit only one-to-one, and the Hope unit (a small unit aimed at supporting indeterminate sentenced prisoners in their sentence progression) had continued to provide some important progression work throughout the restricted regime. However, contact by prison offender managers with those on their caseload was variable. The quality of resettlement planning was poor, with resettlement plans still being developed without direct engagement with the prisoner, either face-to-face or by telephone. Some basic resettlement help was available, but with too many gaps in provision for us to be confident that it was fully effective.

In conclusion, managers, staff and prisoners had responded well to the pandemic some seven months ago and were still working hard to maintain an environment safe from COVID-19. At the time of our visit, it was unclear how the new restrictions in the community would affect the prison's pathway to recovery, but it is important that the prison delivers on the improvements we identify in this report, particularly in regaining a clear focus on rehabilitation and resettlement.

Charlie Taylor
HM Chief Inspector of Prisons
November 2020

Fact page

Task of the establishment
HMP Humber is a category C resettlement prison for adult men.

Certified normal accommodation and operational capacity (see Glossary of terms)
Prisoners held at the time of this visit: 925
Baseline certified normal capacity: 952
In-use certified normal capacity: 952
Operational capacity: 1,062

Prison status (public or private) and key providers
Public

Physical health provider: City Health Care Partnership Community Interest Company
Mental health provider: City Health Care Partnership Community Interest Company
Substance use treatment provider: City Health Care Partnership Community Interest Company
Prison education framework provider: Novus
Community rehabilitation company (CRC): Humberside, Lincolnshire and North Yorkshire CRC
Escort contractor: GEOAmey

Prison group/Department
Yorkshire

Brief history
HMP Humber was formed in June 2013 by the amalgamation of two former prisons, HMP Everthorpe (originally opened as a borstal in 1958) and HMP Wolds (opened in 1992 as a category B establishment, and the first privately run prison in Europe).

Short description of residential units

Zone 1	comprises wings A to G. These are small, open-gallery units.
Zone 2	comprises wings H to N. Apart from a modern induction block, these are mostly older, tier-style units, and include the segregation unit.

Name of governor/director and date in post
Marcella Goligher (since October 2016)

Independent Monitoring Board chair
Paul Holland

Date of last inspection
21 November, 4–8 December 2017

About this visit and report

A1 Her Majesty's Inspectorate of Prisons (HMI 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.

A2 All visits 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 21 bodies making up the NPM in the UK.

A3 During a standard, full inspection HMI Prisons reports against *Expectations*, the independent criteria against which we inspect outcomes for those detained. Inspection teams of up to 12 people are usually in establishments across two weeks, speaking to prisoners and staff, observing prison life and examining a large amount of documentation and evidence. The COVID-19 pandemic means that it is not currently possible to carry out inspections in the same way, both for health and safety reasons and because it would not be reasonable to expect places of detention to facilitate a full inspection, or to be assessed against our full set of *Expectations*, at this time.

A4 HMI Prisons has therefore developed a COVID-19 methodology to enable it to carry out its ongoing, statutory duty to report on treatment and conditions in detention during the current challenging circumstances presented by COVID-19. The methodology has been developed together with health and safety guidance and in line with the principle of 'do no harm'. The methodology consists of three strands: analysis of laws, policies and practice introduced in places of detention in response to COVID-19 and their impact on treatment and conditions; seeking, collating and analysing information about treatment and conditions in places of detention to assess risks and identify potential problems in individual establishments or developing across establishment types; and undertaking scrutiny visits to establishments based on risk.

A5 HMI Prisons first developed a 'short scrutiny visit' (SSV) model in April 2020 which involved two to three inspectors spending a single day in establishments. It was designed to minimise the burdens of inspection at a time of unprecedented operational challenge, and focused on a small number of issues which were essential to the safety, care and basic rights of those detained in the current circumstances. For more on our short scrutiny visits, see our website: http://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/short-scrutiny-visits/.

A6 As restrictions in the community are eased, and establishments become more stable, we have expanded the breadth and depth of scrutiny through longer 'scrutiny visits' (SVs) which focus on individual establishments, as detailed here. The SV approach used in this report is designed for a prison system that is on the journey to recovery from the challenges of the COVID-19 pandemic, but recognises that it is not yet the right time to reintroduce full inspections. SVs provide transparency about the recovery from COVID-19 in places of detention and ensure that lessons can be learned quickly.

A7 SVs critically assess the pace at which individual prisons re-establish constructive rehabilitative regimes. They examine the necessity and proportionality of measures taken in response to COVID-19, and the impact they are having on the treatment of and conditions

for prisoners during the recovery phase. SVs look at key areas based on a selection of our existing *Expectations*, which were chosen following a further human rights scoping exercise and consultation.

A8 Each SV report includes an introduction, which will provide an overall narrative judgement about the progress towards recovery. The report includes a small number of key concerns and recommendations, and notable positive practice is reported when found. Reports include an assessment of progress made against recommendations at a previous SV, but there is no assessment of progress against recommendations made at a previous full inspection. Our main findings will be set out under each of our four healthy prison assessments.

A9 SVs are carried out over two weeks, but will entail only three days on site. For more information about the methodology for our scrutiny visits, including which *Expectations* will be considered, see our website: http://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/scrutiny-visits/

Summary of key findings

Key concerns and recommendations

S1 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.

S2 During this visit we identified some areas of key concern and have made a small number of key recommendations for the prison to address.

S3 **Key concern:** Prisoners located in the reverse cohort unit cells on F and H wings had very little time unlocked, much less than other prisoners elsewhere in the prison. On most days, this amounted to 50 minutes for showers, cell cleaning and outdoor exercise, and on Fridays this was only 20 minutes in total, with no time to go outside.

Key recommendation: Prisoners located in the reverse cohort unit cells should have more time out of cell each day, equivalent to that received by other prisoners living on the main wings.
(To the governor)

S4 **Key concern:** In our survey, only 37% of prisoners who had been on an assessment, care in custody and teamwork (ACCT) case management document said that they felt cared for by staff. This finding was at odds with most of the documentation we reviewed and the generally positive feedback we received from prisoners during our visit. However, the lack of Listener support during the pandemic and the unusually high use of anti-ligature clothing may have contributed to this perception.

Key recommendation: Managers should investigate why so few prisoners who have been supported through ACCT procedures felt cared for by staff and use the findings to inform an improvement strategy.
(To the governor)

S5 **Key concern:** The complaints system was not working well. In our survey, 26% of prisoners said that they could not make a complaint easily. Complaint forms were not readily available, and the arrangements for collecting complaints from the secure post boxes and dealing with allegations of discrimination were poor. Responses to complaints often failed to deal with all the issues raised, and some (including serious allegations about staff) were not investigated appropriately.

Key recommendation: Prisoners should be able to make complaints without impediment. These should be processed efficiently and effectively including thorough investigations and comprehensive responses that address the issues raised.
(To the governor)

S6 **Key concern:** There was no reliable means of identifying prisoners with protected and minority characteristics, and their needs were not being systematically assessed or monitored, or their interests protected or promoted.

Key recommendation: Prisoners with protected and minority characteristics should be identified clearly, their needs thoroughly assessed, and arrangements

put in place to ensure that they receive access to the services and support they need.
(To the governor)

S7 **Key concern:** Prisoners' dental health needs were not being fully met owing to continuing restrictions in the regime and social distancing measures. Attendance rates were poor and the waiting list was long, with some patients waiting up to six months for treatment.

Key recommendation: Dental treatment should be provided promptly, and be equivalent to that delivered in the community.
(To the governor)

S8 **Key concern:** A lack of multidisciplinary clinical governance of pharmacy services, reporting of controlled drug incidents, and errors in medicines dispensing and administration had resulted in clear risks to prisoners.

Key recommendation: Pharmacy services and medicines management should be consistently and assertively scrutinised, to minimise risks to the safety of prisoners.
(To the governor)

S9 **Key concern:** At the start of the restricted regime at the end of March 2020, face-to-face resettlement planning and support had been suspended, which was totally understandable at that time. However, seven months later there was still too little evidence of direct contact between the CRC and prisoners when assessing resettlement needs, which had left resettlement planning over-reliant on the use of a self-assessment questionnaire.

Key recommendation: All prisoners due for release should be actively and directly involved in assessing and identifying their resettlement needs, and in making plans to address these.
(To the governor)

Notable positive practice

S10 We define notable positive practice as innovative practice 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.

S11 Inspectors found the following examples of notable positive practice during this visit.

- Consultation arrangements were good. In particular, the 'Humber Pilot scheme' (a peer-led initiative) had credibility among prisoners and provided a professional mechanism whereby views could be exchanged constructively between staff and prisoners. (See paragraph 2.11)
- The thoughtful approach adopted by the chaplaincy ensured that prisoners' spiritual and pastoral needs continued to be met throughout the restrictions. This included running small religious instruction groups daily and conducting wing-based bereavement counselling, as well as issuing written sermons as an alternative to corporate worship. The chapel had reopened in August, enabling prisoners to access support in person. (See paragraphs 2.18–2.20)

- Health screening at reception was enhanced by the addition of an assessment of mental health and substance misuse needs by a mental health professional, which helped to identify additional vulnerabilities and risks. (See paragraph 2.34)

Section 1. Safety

In this section, we report mainly on leadership and management; arrival and early days; managing prisoner behaviour; and support for the most vulnerable prisoners, including those at risk of self-harm.

Leadership and management

1.1 The establishment had responded positively to the COVID-19 restrictions and had managed a local outbreak among staff in May well. At the time of our visit, few staff had tested positive and no prisoners were currently positive.

1.2 In our surveys, about three-quarters of staff and prisoners said that the current restrictions were necessary. The health and safety procedures for staff when entering the prison were sensible, and included temperature checks and a limit on the number of staff in the gatehouse at any one time. Just over two-thirds of prisoners in our survey said that they felt they were being kept safe from the virus. Overall, three-quarters of respondents to our staff survey said that reasonable steps were being taken to keep them safe from the virus, but half of frontline operational staff respondents reported that this was not the case.

1.3 Signage and markers throughout the prison emphasised the importance of social distancing, but in many areas, particularly in the older parts of the prison, with narrow corridors, this was very difficult to achieve. In our staff survey, 69% of frontline operational staff respondents said that it was difficult to adhere to social distancing from colleagues, and 64% that it was difficult to socially distance from prisoners. We were told that there was an adequate supply of personal protective equipment (PPE; see Glossary of terms) in the prison. Face masks and coverings were being used and we saw generally good adherence to this by staff, but less so by prisoners. Extra cleaning continued to be undertaken on the wings. In our surveys, 77% of staff respondents said that their work areas were clean, and the same proportion of prisoners said that the communal areas of the prison were clean.

1.4 Ongoing communication was effective. The majority of staff who responded to our survey said that they had been kept informed about what was expected of them. Prisoners were also very positive; 86% said that they knew what the restrictions were, and 85% that the reasons for them had been explained.

1.5 Most staff (79%) who responded to our survey said that their well-being had been supported during the pandemic, but less than half (48%) of frontline operational staff respondents felt this way. Just under half of the staff surveyed said that their work morale had declined during the pandemic.

1.6 Some cautious steps towards recovery had been taken over recent months, such as increasing the amount of time out of cell for prisoners not in work, running gym sessions and reopening some workshops, with a reduced capacity. However, the governor and senior managers were frustrated by the slow pace of recovery imposed by national guidance, and the lack of local autonomy. The announcement of a second national lockdown in the community, due to start on the day after our visit, left the prison uncertain about their next steps. However, they were hoping that the progress made over recent months could be maintained, while accepting that face-to-face social visits would be temporarily suspended again.

1.7 Despite an increase in the amount of time out of cell, most prisoners were locked up for almost the whole day, being allowed out for only 90 minutes, and we found that this was less than one hour for new arrivals during their first 14 days. Steps taken at the start of the restricted regime to support prisoners in managing isolation remained in place – for example, extra telephone credit, increased wages and the use of video calling to maintain contact with the outside world. However, most prisoners we spoke to were extremely bored and frustrated as a result of prolonged periods locked in their cell. Some clearly and powerfully described the negative impact this was having on their physical and mental well-being.

1.8 In-cell telephones were highly valued by prisoners, but the prison continued to limit the amount of time that these could be used to 2.5 hours a day. The reasons for this local restriction were unclear, and it caused problems for a few prisoners we spoke to (see also paragraph 4.4).

1.9 Some important aspects of rehabilitation and resettlement work had been suspended or reduced at the start of the restricted regime, and recovery had been slow nationally. While the governor and senior managers were committed to restoring the focus on rehabilitation and resettlement at the earliest opportunity, we considered some of the restrictions difficult to defend seven months into the restricted regime. For example, over several months the assessment of resettlement needs had been undertaken without direct contact with the prisoner, either by telephone or face to face, which was poor and it was difficult to see why this lack of engagement had persisted for so long (see also paragraph 4.19 and key concern and recommendation S9).

Arrival and early days

1.10 Transport arrangement to the prison were appropriately focused on the management of the risks posed by COVID-19, including restrictions on the number of prisoners on each van, to support social distancing, and the sanitising of vehicles between uses.

1.11 The reception area was clean and well laid out, with good consideration given to reducing the risk of contamination from COVID-19. Reception processes were conducted efficiently, and good attention was given to maintaining an appropriate distance between staff and prisoners. Use of the body scanner reduced the need for physical contact between staff and prisoners, while enabling the identification of illicit items.

1.12 Screens had been installed in the interview room, where property was checked and the initial safety interview was undertaken. The prison had recently identified some shortfalls in the depth of enquiry undertaken during the initial safety interview, and was taking steps to rectify this.

1.13 A Listener (see Glossary of terms) was now available in reception, following several months of the scheme being suspended. All new arrivals had the opportunity to speak to the Listener, but this was undertaken in the main passageway, which provided little privacy.

1.14 New arrivals were taken to one of the two reverse cohort units (RCUs; see Glossary of terms) on F and H wings, usually within two hours of arrival. First night cells were clean and well prepared, and when cell sharing was necessary prisoners were given the opportunity to choose who they shared with. New prisoners were separated from all other prisoners for their first 14 days. However, RCU prisoners from F wing shared an exercise yard with prisoners from other units, and social distancing was not always adhered to, which presented an avoidable risk of the virus being transmitted.

1.15 Most new arrivals were able to contact friends and family using their in-cell telephones. When restrictions prevented this, staff made calls for them, to inform their families of their safe arrival.

1.16 The full induction programme had been suspended throughout the pandemic, and now consisted only of a short face-to-face meeting with wing staff and access to a set of laminated information sheets to read. None of those we spoke to on the RCU on F wing said that they had received this written information, and there was no assessment of prisoners' understanding of the information. A member of the chaplaincy visited all new arrivals but, beyond that, the level of engagement with prisoners provided through the induction programme was poor.

1.17 The daily regime for new arrivals was far too limited for their first 14 days. They received only a 20-minute domestic period and 30 minutes of outdoor exercise, and on Fridays they had only 20 minutes in total, with no time for outside exercise. Some of the prisoners we spoke to described the negative impact that this was having on their physical and mental well-being (see key concern and recommendation S3).

Managing behaviour

1.18 In our survey, 17% of prisoners said they felt unsafe at the time of our visit and 18% said they had been victimised by other prisoners. Of more concern, however, was that 34% said they had been victimised by staff, but the reasons for this perception were unclear and required further investigation.

1.19 According to HM Prison and Probation (HMPPS) data, the number of violent incidents had been falling steadily over the previous 12 months and had continued to do so during the restricted regime. For example, over the last six months, assaults on staff had fallen by around 50%, and on prisoners by almost 75%.

1.20 The weekly safety intervention meeting continued to be a useful forum for discussing the management of prisoners with complex problems, both from a violence and a vulnerabilities perspective. The scope of this forum had been expanded during the regime restrictions, to mitigate the suspension of the safety committee. Data analysis had continued throughout the restricted regime, and the recent combining of the safety and security teams looked promising and had already provided strong links across these important areas.

1.21 Challenge, support and intervention plans (see Glossary of terms) were used to manage the perpetrators and victims of violence, as well as the prisoners who chose to self-isolate. However, the range of interventions available to change behaviour was extremely limited, mainly consisting of additional observations. A range of innovative measures that had been introduced to support a few prisoners who chose not to engage with others was stopped at the start of the restricted regime.

1.22 In response to the imposition of restrictions, and in recognition of the high level of compliance and understanding of the population, all prisoners had been placed on the highest level of the incentives scheme. This provided the majority with additional benefits, to mitigate the loss of access to a full regime. Most prisoners had responded positively, and this initiative had worked well.

1.23 The use of force, both planned and unplanned, had decreased steadily since the start of the restricted regime. Good monitoring was provided by a full-time use of force coordinator, overseen by the head of safety.

1.24 Security intelligence was well managed and responses to emerging threats in the prison were acted on quickly. Intelligence-led searching had continued throughout the restricted regime, and the prevalence of weapons, drugs, alcohol and mobile phones had reduced since April.

1.25 Use of the segregation unit was low for the size of the population. The unit was bright, clean and in good order. Prisoners we spoke to on the unit were very positive about their interactions with unit staff, saying that they were treated well and that staff were supportive in encouraging them to return to normal location.

1.26 According to HMPPS data, the number of adjudications had fallen by around 50% over the last seven months. All but the most serious of offences attracted a suspended award. Serious offences were escalated to the independent adjudicator via video link or referred to the police for prosecution.

Support for the most vulnerable, including those at risk of self-harm

1.27 There had been 250 incidents of self-harm reported from April to September 2020, which was not excessive in comparison with similar establishments. The overall trend had been downwards since our inspection in 2017 and during the pandemic months.

1.28 The prison had made efforts to prevent self-harm. Regular well-being checks on all prisoners had helped to identify individual risks and vulnerabilities during the restricted regime, when prisoners spent little time out of their cells. Staff followed up on the resulting actions and prioritised these prisoners for distraction activities to reduce boredom and anxiety. These activities included matchstick kits and stress balls to supplement the paper-based puzzles available on the wings (see section on purposeful activity).

1.29 The formal Listener scheme was only just being reinstated during our visit, following its suspension (see paragraph 1.13). Listeners had provided informal and limited support during periods of unlock but we did not fully understand why there had been no confidential Listener service over so many months. Prisoners could contact the Samaritans via the in-cell telephones 24 hours a day, but some staff and prisoners were unaware of this provision during the night, and this was of limited use for prisoners in double cells, who could not have a private telephone conversation.

1.30 'Andy's Man Club', a peer-led support scheme, had restarted in late July and was attended by as many as 250 prisoners each week, during the evenings.

1.31 In our survey, only 37% of prisoners who had been on an assessment, care in custody and teamwork (ACCT) case management document for prisoners at risk of suicide or self-harm said that they felt cared for by staff. However, in our conversations with prisoners, most reported positively about the support they had received, given the constraints of the regime restrictions. Six prisoners had been placed in anti-ligature clothing since September 2020 and we were not confident that these decisions had always been appropriate. One prisoner told us that the use of anti-ligature clothing had felt like a punishment, despite his need for help. This, and the lack of a formal Listener scheme, may have contributed to the negative perception of support shown in our survey (see key concern and recommendation S4).

1.32 In our review of a sample of ACCT documents, we found empathetic and compassionate individualised reporting. In a few cases, staff had not evidenced their conversations with prisoners well enough but we considered that prisoners being cared for using the ACCT process generally received good support. Few prisoners remained on ACCTs for long periods.

1.33 Managers had ensured that prisoners at particular risk from COVID-19 were able to shield themselves (see Glossary of terms) from others without losing time out of cell. Staff responded well to prisoners with increased levels of anxiety about infection.

Section 2. Respect

In this section, we report mainly on staff-prisoner relationships; living conditions; complaints, legal services, prisoner consultation, food and canteen; equality, diversity and faith; and health care.

Staff-prisoner relationships

2.1 The relationships we observed between staff and prisoners were positive and constructive. Use of first names was common and there appeared to be a mutual understanding about the challenges that each group faced during the pandemic.

2.2 Our observations were reinforced by the survey findings, where 77% of prisoners said that most staff treated them with respect, and 73% that they had a member of staff they could turn to if they had a problem.

2.3 However, only 49% of prisoners responding to our survey said that a member of staff had talked to them over the past week about how they were getting on. The formal key worker scheme (see Glossary of terms) had not been running since the end of March, and the regular contact now being recorded consisted mainly of weekly well-being checks focused on immediate welfare issues, rather than anything more structured. There was a lack of continuity from officers who undertook these checks and none of the planned and purposeful contacts that the key worker scheme was designed to provide.

Living conditions

2.4 A reduction in the population had reduced the number of prisoners sharing cells designed for one by about 30 prisoners, to 94.

2.5 The older accommodation in zone 2 had been refurbished and redecorated, and all prisoners now lived in decent conditions. In our survey, almost all prisoners said that they received cell cleaning materials which enabled them to keep their cells clean, and wing cleaners kept the communal areas clean and tidy. In our survey, 77% of prisoners said that communal areas were clean.

2.6 Cells were adequately equipped but a small number had some items of furniture missing or broken. The kit exchange scheme worked reliably, and wing-based laundry arrangements were well organised. In our survey, 81% of prisoners said that they had enough clean clothes for the week, and 89% that they received clean sheets each week. In our survey, almost all prisoners (93%) said that they could shower daily.

Complaints, legal services, prisoner consultation and food and shop

2.7 The volume of complaints was not excessive but was now rising, having dropped sharply when the regime restrictions were imposed. Complaint forms were not readily available on several wings. The secure post boxes for complaints were emptied at night by a uniformed member of staff, which was not good practice and potentially undermined prisoner confidence in the system.

2.8 Most complaints were answered promptly and were polite, but the overall quality of responses was not sufficiently good. Some managers failed to investigate and address all the issues raised by the prisoner, often avoiding the most critical questions. Many also failed to meet the complainant when it would have been helpful. Complaints involving allegations of discrimination were not routinely referred to the equality and diversity manager for investigation under the discrimination incident report form (DIRF) system (see also paragraph 2.16). Quality assurance processes were not sufficiently robust to identify these problems, with the result that we found some serious allegations about staff behaviour which had not been properly investigated and received inadequate replies.

2.9 We considered that these failings may have explained why, in our survey, 26% of prisoners said that they could not make a complaint easily. They may also have contributed to prisoner perceptions about victimisation by staff (see paragraph 1.18 and key concern and recommendation S5).

2.10 Legal visits had been reinstated on 21 September 2020 and were sufficiently private. In-cell telephony meant that prisoners had good access to telephones to speak to legal advisers. Legal letters were not included in the local policy to photocopy all incoming mail, and only eight legal letters had been opened in error in the previous seven months.

2.11 Regular monthly consultation meetings on the wings had recently been reinstated. In addition, the 'Humber Pilot' (a well-established and well-organised peer-led initiative) continued to operate effectively and enabled prisoners to express their views. The scheme involved carefully selected and trained prisoners representing the views of others. They met senior members of staff weekly, to raise issues and share information. Prisoners we spoke to who were involved in this initiative said that they felt listened to, and believed that their views were taken seriously. Residential governors had also recently set up weekly wing-based drop-in clinics, where prisoners could speak to them about issues of concern.

2.12 In our survey, 63% of prisoners said that the food was good or reasonable. Regime restrictions had removed the facility to eat meals communally, which meant that prisoners had to eat their meals in their cell. Consultation arrangements relating to catering were good, and considerable efforts were made to try to accommodate prisoners' preferences. We saw examples of changes being introduced following prisoners' suggestions.

2.13 The prison shop was administered efficiently, and 74% of prisoners in our survey said that they could access the shop if they wanted to. Shop orders were now distributed to prisoners at their cell doors, which had the potential to reduce bullying.

Equality, diversity and faith

2.14 Work to promote equality and diversity remained weak, and until very recently there had not been a dedicated manager in post to oversee this key area of work since the start of 2020. Managers acknowledged the weaknesses in this area and understood what needed to be done. Despite this, in our survey there were few significant differences between the responses from minority groups and mainstream prisoners about their experiences at the establishment.

2.15 Senior managers had been allocated to lead on each of the protected and minority characteristics, but there was no formal record of feedback on work undertaken recently, or outcomes achieved. Equality action team (EAT) meetings had been suspended early in the pandemic but had restarted in July. However, no prisoners had been present for the first few meetings, and records showed little useful analysis or monitoring of data, and few of the recommendations in the action plan had been completed. An EAT meeting took place during

our visit, and attendance was better than in previous months, with prisoner representatives present. The quality of information being discussed had improved, and analysis of adjudications data had now restarted.

2.16 Records showed that two to three DIRFs had been submitted each month over the previous six months, which was low considering the size of the population. We found several examples of issues raised under the generic complaints system which should have been treated as DIRFs (see also paragraph 2.8).

2.17 There was no reliable means of identifying prisoners with protected and minority characteristics, and their needs were not being systematically assessed or monitored, or their interests protected or promoted (see key concern and recommendation S6). Black and minority ethnic prisoners made up around 11% of the population, and discussion forums had taken place for them. In addition, they had recently been involved in helping to provide a successful programme of events for Black History Month. The views of prisoners from other minority groups were not being actively sought. For example, just over 30% of the population was under the age of 29 but there was no strategy to respond to their specific needs. Foreign national prisoners made up just under 5% of the population but, beyond designating a member of staff to support them, little work in this area had been done recently.

2.18 The chaplaincy had remained active throughout the restricted regime and had introduced several useful initiatives to help ensure that the spiritual and pastoral needs of prisoners continued to be met.

2.19 Chaplains continued to see prisoners during the induction process. The chapel had reopened in August, enabling prisoners to access support in person. Religious instruction groups were run daily, involving up to six prisoners in each group. Before the introduction of the restricted regime, there had been a high level of need for bereavement counselling. In the absence of visiting specialists who had previously carried out this work, members of the chaplaincy were providing this support, seeing prisoners individually on the wings for up to six sessions.

2.20 Corporate worship had yet to resume but, as an alternative, written weekly sermons were issued to prisoners who would normally have attended the chapel. Effective use was also being made of tablet computers, to enable prisoners to livestream the funerals of friends or family.

Health care

2.21 Health services were provided by City Health Care Partnership (CHCP) and had progressed since our inspection in 2017. The prison, the health commissioner and CHCP worked effectively at strategic and operational levels to meet the health needs of the population, and imaginative service transformation plans were progressing, despite the COVID-19 restrictions.

2.22 Partners implemented joint operational contingency plans for COVID-19 and had created workable recovery plans, underpinned by a joint understanding of risks. Public Health England had joined the partnership, offering valued guidance, particularly during an outbreak of the virus in May 2020.

2.23 Leadership from CHCP had improved following a period of change. Consultations were advanced to strengthen management and risk-sharing between Hull and Humberside prisons. The recruitment of sufficient nurses was a chronic problem, offset by using long-term agency

nurses and the introduction of new roles, so that gaps in staffing did not disrupt service delivery.

2.24 Health care staff were aware of procedures to deal with COVID-19 and were equipped with suitable personal protective equipment (PPE; see Glossary of terms). There were measures to minimise transmission of the virus throughout the prison, but not all officers we spoke to could recall the correct procedure for cardiopulmonary resuscitation.

2.25 New arrivals were monitored for COVID-19 during the reception screening, followed by a comprehensive health assessment within 72 hours. All prisoners who were isolating because of the virus received enhanced monitoring. During the restricted regime, health care staff had provided vitamin D supplements to prisoners who needed them.

2.26 Most primary care clinics had stopped temporarily at the end of March 2020 and several had yet to resume. Revised arrangements for triage and treatment by nurses and GPs, introduced during the restrictions, ensured reasonable access for patients, with a waiting time to see the GP of seven days, and urgent cases could be seen on the same day. However, following the restrictions, prisoners had waits of up to six months for some specialist clinics, and at the time of our visit there were 95 patients waiting to see the optician, and 42 to see the podiatrist. Prisoners had had good access to hospital appointments during the regime restrictions, although some hospitals had initially limited the number of appointments because of COVID-19.

2.27 Clinicians had made more use of technology to treat patients in the last six months, including telemedicine consultations (see Glossary of terms) with hospital specialists such as hepatologists. Health care staff were frustrated that they did not have confidential access to the in-cell telephony system, which prevented them from adopting new ways of working that we have seen in other prisons.

2.28 The dental surgery continued to offer emergency advice and treatment during the COVID-19 restrictions. The surgery was fully equipped to offer aerosol generating procedures with minimised risks, in line with national guidelines. However, in our survey only 13% of prisoners said that it was easy to see the dentist. Dental staff were frustrated that they could not offer full clinics owing to restrictions in the regime and social distancing requirements, with only 50% of the capacity being allocated for appointments. Attendance rates were poor, commonly with as few as 20% turning up for an appointment. This had led to over 90 prisoners waiting up to six months for routine treatments, such as tooth fillings, at the time of our visit, which increased the risk of their experiencing a further deterioration in dental health (see key concern and recommendation S7).

2.29 Social care provision had improved since 2017, and there was with one patient in receipt of a care package (see Glossary of terms) provided by CHCP at the time of our visit. Good end-of-life care was available.

2.30 CHCP sub-contracted pharmacy services to Focus Healthcare Limited ('Focus'). Pharmacy staff distributed in-possession medicines to prisoners. We were not confident that all errors in this process, such as prisoners receiving either incorrectly labelled medicines or in-possession medicines which were not theirs, had been reported. Focus was now working to improve matters, following a contractual notice to improve.

2.31 Where necessary, CHCP nurses and Focus pharmacy staff supervised prisoners when taking medicines. There had been too many errors in the administration of medicines in 2020, with several prisoners receiving the wrong ones. Before our visit, CHCP had appointed a senior pharmacy member of staff to oversee improvements, and the medicines administrations we observed were exemplary.

2.32 There was insufficient emphasis on shared risk management. For example, Focus pharmacists had not attended the multidisciplinary medicines management committee for almost six months, and controlled drugs that had gone missing in the pharmacy had not been appropriately reported at the time, giving rise to concerns about safety (see key concern and recommendation S8).

2.33 CHCP mental health and substance misuse teams worked closely together and had maintained a responsive service, despite being affected by staff shielding since March. Access to psychiatry advice had improved since 2017 and had continued during the restrictions.

2.34 All new prisoners were seen in reception by a mental health professional for an assessment of mental health and substance misuse needs, which helped to identify additional vulnerabilities and risks. At the time of our visit, there were 350 prisoners on the mental health caseload, which is an exceptionally large number, and in our survey 57% of prisoners said that they had a mental health problem. Staff had serious concerns that the long periods confined to their cells would affect these patients' well-being, and cause boredom, low mood and sleep inversion, leading to increased prescribing.

2.35 Face-to-face contact with these patients, and the running of therapeutic groups, had been severely cut back during the restricted regime. At the time of our visit, because of social distancing requirements, group therapies remained unavailable. In-cell workbooks and leaflets were used to mitigate partially the curtailed therapeutic options, and mental health and substance misuse practitioners carried out welfare checks on the most vulnerable on the wings.

2.36 The care programme approach was used to manage up to 20 patients with complex mental disorders and to plan for transfer or release, although some external mental health services had been unable to participate during the restrictions. One patient had been waiting several weeks for the completion of his transfer to a secure bed under the Mental Health Act, which was unacceptable.

2.37 At the time of our visit, 337 prisoners were receiving psychosocial support from the substance misuse team, including 192 on opiate substitution therapy (OST). The OST administration procedures we observed were very good, and clinical reviews occurred in line with national guidelines.

2.38 Pre-release preparation for prisoners was good, and included medications to take with them, help to find a GP in the community, harm minimisation advice and naloxone (an opiate reversal agent) as necessary. Advice was given on minimising COVID-19 transmission, and a week's supply of PPE was provided, to encourage prisoners to keep safe and allay their fears.

Section 3. Purposeful activity

In this section we report mainly on time out of cell; access to the open air; provision of activities; participation in education; and access to library resources and physical exercise.

3.1 Since 29 September 2020, most prisoners had had at least 1.5 hours out of cell a day, generally in two 45-minute periods, six days a week. This included only 45 minutes for outside exercise, which is less than we expect. On Fridays, there was no outside exercise. This resulted in long periods (at least 40 hours) between Thursday afternoon and Saturday morning when prisoners were only out of their cells for a shower/cell clean and very short periods to collect meals.

3.2 Four workshops delivering commercial contracts had reopened, at a much reduced capacity and with safe systems of working, at the end of October 2020. This meant that around 23% of prisoners now had activity for up to 5.5 hours a day, in addition to time for a shower and in the open air in the evening. None of these workplaces offered qualifications, but prisoners very much appreciated the chance to keep active and be out of their cell.

3.3 During the period of restrictions, teachers provided in-cell work to prisoners previously enrolled in education classes. At the end of September, they were allowed see individual prisoners on the wings, and within six weeks they had delivered around 800 one-to-one sessions. Classroom activity had been reinstated for a cleaning course.

3.4 A range of distraction activities, such as word searches, number puzzles and colouring books, were freely available on the wings, but some prisoners found that, after many months, they no longer provided adequate distraction.

3.5 Outside physical exercise had been reinstated in mid-May, well before many other prisons had managed this. Fifteen prisoners at a time could participate in circuits on the exercise yard, and each wing had three or four opportunities a week. Provision had moved indoors in mid-October and sessions now included resistance/cardiovascular equipment and badminton, which prisoners greatly appreciated. However, on some wings, prisoners prepared the attendance lists and we were not confident that all prisoners were being given equitable access.

3.6 Prisoners were still unable to visit either of the libraries, but library provision had been maintained, except for a 10-day period at the start of the restrictions. Prisoners could request books, audio books and DVDs via applications, and these were usually delivered on either the same or next day. The number of books loaned had reduced considerably because of the physical challenges of moving volumes of books around the site, but the proportion of prisoners using the library service each month had been maintained.

Section 4. Rehabilitation and release planning

In this section, we report mainly on contact with children and families; sentence progression and risk management; and release planning.

Contact with children and families

4.1 Family support workers had remained on site throughout the period of restrictions, offering one-to-one support – for example, working with prisoners for family court hearings and parental assessments. These workers had also provided interventions to those in crisis.

4.2 The prison had reintroduction social visits in early July, and over 300 visits had taken place since then, but this remained below the available capacity. New restrictions in the community were about to impose a further period of suspension of these, starting on the day after our visit.

4.3 Social distancing arrangements in the visits hall included the installation of 12 booths, each fitted with a COVID-19-safe acoustic voice conductor. Some prisoners felt that the restrictions on visitors were too strict.

4.4 In our survey, 98% of respondents said that they could use the telephone every day. All cells had telephones, and the prison continued to offer additional credit to help prisoners maintain contact with the outside world. However, a limit of 2.5 hours of call time per day had been imposed without any obvious rationale (see also paragraph 1.8). The prison had recently started to identify prisoners with low telephone usage, and arranged for staff to contact them to discuss their support needs.

4.5 Video calling ('Purple Visits'; see Glossary of terms) had started in July, with up to 27 sessions available each day. Since then, 513 sessions had been booked, which represented 21% of available sessions, and the prison had not yet fully explored the reason why this facility was so underused.

4.6 Prisoners had been offered encouragement and support to write letters. In our survey, 41% of respondents said that they had experienced problems in sending and receiving mail, but we could not find an explanation for this during our visit.

Sentence progression and risk management

4.7 Over half of prisoners were assessed as presenting a high risk of serious harm to others and were serving sentences of four years or more, including 99 who were serving an indeterminate sentence.

4.8 The staffing levels in the offender management unit had returned to the same level as before the pandemic. Prison-based probation officers managed those presenting a high risk of harm, which was appropriate.

4.9 In our survey, only 43% of prisoners who knew about their sentence plan said that staff were helping them to achieve it. Since the start of the restricted regime, the level of contact between prisoners and their prison offender managers (POMs), to support them in their

sentence and drive progression, was variable, and prison managers did not have sufficiently good oversight of this. However, much of the contact was now face to face, which was an important improvement in a training and resettlement prison.

4.10 Information sharing between the prison and community-based offender managers was reasonably good. The prison made good use of teleconferencing for three-way discussions between the POM, the prisoner and the community offender manager, in order to establish progression plans.

4.11 Most prisoners had been sentenced to more than a year in prison, and they needed a full assessment of their risk to others and of their offending-related needs, using the offender assessment system (OASys). Initial assessments were overdue for almost 100 prisoners, most of whom had been transferred from HMP Hull, often arriving with too little time to complete the assessment within the target timescale. We found that only around two-thirds (68%) of sentence plans and OASys assessments had been reviewed within the past 12 months.

4.12 The prison had resumed the provision of offending behaviour programmes, although these were now delivered one to one because of the restricted regime. A cohort of prisoners had recently completed the Thinking Skills Programme, and a further cohort was nearing completion of Resolve. The additional time to complete these programmes on a one-to-one basis meant that fewer prisoners than usual would have the opportunity to complete offending behaviour work before they were released.

4.13 A 'Restorative Life Skills' programme, which addressed how to deal with conflict, manage emotions and maintain healthy relationships, had been introduced in September. Since then, four long-sentenced prisoners had completed it on a one-to-one basis, and another four had recently started it.

4.14 The Hope unit offered additional support for 39 of the indeterminate-sentenced prisoners. This included dedicated POMs, psychologists and key workers on the unit. Throughout the period of restrictions, staff on the unit had had a focus on supporting parole applications, and in that time 14 of these prisoners had been granted release. However, opportunities to demonstrate progress were limited by the restricted regime on the unit. At the time of our visit, the unit shop remained closed, denying these prisoners the opportunity to develop life skills such as budgeting and self-catering.

4.15 Recategorisation reviews had continued to take place and were mostly timely. Some progressive transfers had continued, with 37 prisoners moving to open conditions in the previous three months. However, at the time of our visit, 23 prisoners were still waiting for a transfer, four of whom had been waiting since June, and this was hindering their progression.

4.16 Over the last six months, 147 prisoners had been released on home detention curfew but 30 had been released late, mainly because of the shortage of suitable accommodation in the community or late responses from community-based offender managers.

4.17 The interdepartmental risk management meeting took place each month, with an appropriate focus on release plans for prisoners assessed as posing a high risk of harm and those subject to multi-agency public protection arrangements (MAPPA). Mail and telephone monitoring arrangements were well managed for the 32 prisoners subject to such restrictions, with examples of timely intervention when they breached them. There were 71 prisoners subject to some level of child protection restrictions, and while there was evidence of communication between the staff involved in managing these arrangements (for example, between public protection and visits staff), there was no evidence that these restrictions were reviewed on an annual basis as required.

Release planning

4.18 The establishment had released about 100 prisoners a month over the last six months. Many of these had served sentences of over four years, with a large proportion assessed as presenting high risk of harm to others. The community rehabilitation company (CRC) and Shelter staff remained on site during the restricted regime. However, in our survey only 48% of prisoners who expected to be released within the next three months said that someone was helping them to prepare for this.

4.19 At the start of the restricted regime, face-to-face resettlement planning and support had been suspended, which was totally understandable at that time. At the time of our visit, resettlement plans were being completed about 12 weeks before a prisoner's release, although this process had, for several months, relied solely on the use of a self-assessment questionnaire which was posted to the prisoner. This was poor practice as it failed to provide any direct engagement with the prisoner or any attempt to encourage him fully to explore or discuss his needs and concerns. Even if face-to-face assessment was not deemed possible, staff could have engaged with the prisoner using the in-cell telephone system (see key concern and recommendation S9).

4.20 In addition, the resettlement workers had only very recently started providing face-to-face contact to address resettlement needs, and this took place only with the most complex cases needing more specialist support.

4.21 There were some good examples of work to secure accommodation on release, including the use of legal challenge when a local authority refused to accept a prisoner with a priority need for housing. Despite this, 14% of prisoners released in the previous six months did not have a sustainable address to go to.

4.22 Support in relation to employment, and finance, benefit and debt was poor and usually amounted only to the provision of information leaflets. The previously well-regarded Ready 4 Release programme had been suspended and was to be replaced by a workbook for prisoners to complete in their cells.

4.23 Over 100 prisoners had been considered for the end of custody temporary release or special purpose licence release (see Glossary of terms) schemes, but only one had been deemed suitable.

Section 5. Appendices

Appendix I: Scrutiny visit team

Sandra Fieldhouse	Team leader
Paul Rowlands	Inspector
Ian Macfadyen	Inspector
David Owens	Inspector
Jeannette Hall	Inspector
Scott Ellis	Inspector
Paul Tarbuck	Health care inspector
Amilcar Johnson	Researcher
Joe Simmonds	Researcher
Charlotte Betts	Researcher

Section 6. Further resources

Some further resources that should be read alongside this report have been published with it on the HMI Prisons website. For this report, these are:

Prisoner survey methodology and results

A representative survey of prisoners is carried out at the start of the scrutiny visit, the results of which contribute to our evidence base for the visit. A document with information about the methodology, the survey and the results, and comparisons between the results for different groups are published alongside the report on our website.

Staff survey methodology and results

A survey of staff is carried out at the start of every scrutiny visit, the results of which contribute to the evidence base for the visit. A document with information about the methodology, the survey and the results are published alongside the report on our website.