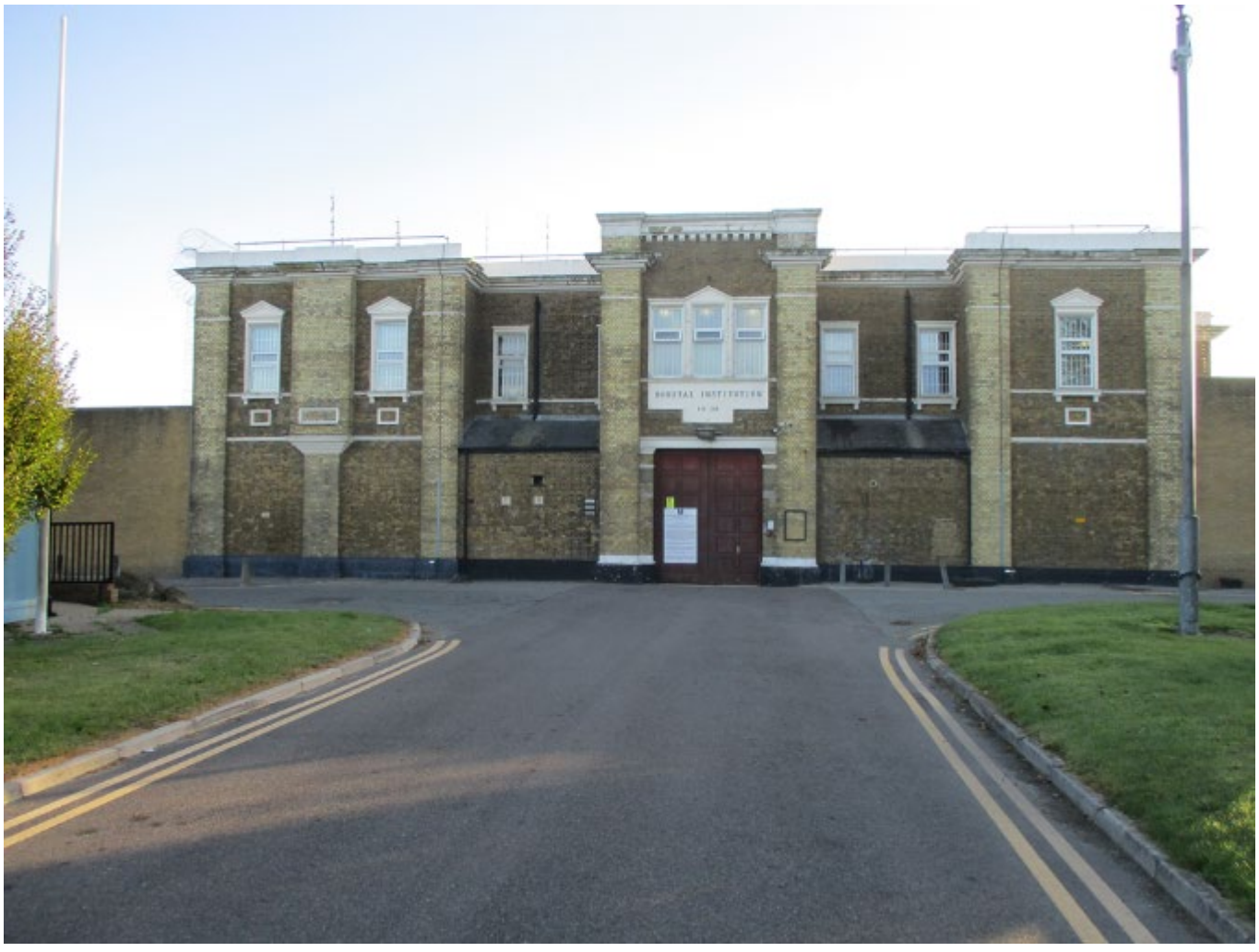
Report on an unannounced inspection of

HMP & YOI Rochester

by HM Chief Inspector of Prisons

4 and 11–15 October 2021



Contents

Introduction

HMP and YOI Rochester, the original borstal, is a category C training and resettlement prison for adult men and young offenders in Kent. When we last inspected in 2017, the prison was in a state of flux, with plans to close it just rescinded. At this inspection the situation had changed radically and, far from closure, there was now talk of potential plans to redevelop the site.

Whether these plans come to fruition remains to be seen, although as our report shows, a key strategic priority for the prison is the need to end overcrowding and radically improve the condition of the living accommodation in which prisoners were held. The establishment comprises a mix of very old house blocks and some relatively new. All, however, were in a very poor condition.

At the time of our inspection Rochester was holding 658 men; some way short of its capacity of just under 700. There was a significant turnover of prisoners each month, although 60% of the population were serving long or indeterminate sentences. About 40% were judged to present a serious risk of harm to others.

Overall, and in the context of the restrictions imposed by the COVID-19 pandemic, this was a reasonable inspection. As we found in 2017, outcomes in safety remained reasonably good, but were not sufficiently good in respect, principally due to the very poor living environment. In purposeful activity outcomes had deteriorated and were now poor – largely a consequence of COVID-19 restrictions – but outcomes had improved in rehabilitation and release planning to the extent that they were now reasonably good.

It was clear that leaders in the prison had prioritised Rochester's response to the pandemic and had, commendably, been successful in mitigating risks. As the prison recovered however, progress to us seemed slow, even tentative. The reasons and explanations we heard for this were often unclear and inconsistent. Too few prisoners were engaged in useful activity and plans to move the prison to the next stage of the HMPPS recovery framework seemed to be fragile and unambitious. It must be acknowledged that another key strategic challenge for the prison – and one that was a significant additional limitation on progress – was the chronic shortage of staff. In common with other prisons in the Kent area, staff attrition rates were high and recruitment very slow. It was not clear that the prison had a credible plan to resolve this.

Rochester was achieving reasonably good outcomes in some important areas. The prison was settled, and prisoners seemed generally accepting, even sanguine about their situation, despite the poor living conditions and lack of activity. It was hard to avoid the sense, however, that with greater confidence, ambition and clarity of purpose from leaders, more could have been achieved. Clearer plans about the prison's future, including how it will be redeveloped, and a robust strategy – probably led by HMPPS – to ensure effective recruitment are the two critical priorities.

Charlie Taylor
HM Chief Inspector of Prisons
December 2021

About HMP & YOI Rochester

Task of the prison/establishment
A category C resettlement prison for adult men and young offenders.

Certified normal accommodation and operational capacity (see Appendix II Glossary of terms)
Prisoners held at the time of inspection: 658
Baseline certified normal capacity: 695
In-use certified normal capacity: 658
Operational capacity: 695

Population of the prison
- 1,350 new prisoners received each year (about 113 per month).
- 44 foreign national prisoners representing 6.5% of the current population.
- 19.8% of prisoners from a black and minority ethnic background.
- An average of 68 prisoners released into the community each month.
- 233 prisoners receiving support for substance misuse.
- An average of 80 prisoners referred for mental health assessment each month.

Prison status and key providers
Public

Physical and mental health provider: Oxleas NHS Foundation Trust
Substance misuse treatment provider: The Forward Trust
Prison education framework provider: Weston College
Escort contractor: GEOAmey

Prison group
Kent and Essex

Brief history
Rochester prison was originally built in 1874 on a former military site above the Medway River. In 1983, Rochester was converted into a youth custody centre and, in 1988, it became a remand centre for Kent courts. In 2011, Rochester was turned into a dual-purpose site for young adult and adult category C prisoners. Following a rescinded closure notice in 2017, it held young adult and adult category C and D prisoners.

Short description of residential units
There were eight residential units:
A wing – drug recovery unit
B, D, E, G and H wings – general accommodation
R and F wings – reverse cohort units and first night centres.

Name of governor and date in post
Dean Gardiner, October 2018

Leadership changes since the last inspection
Phil Wragg, May–September 2018
James Carmichael, February 2016–January 2018

Prison Group Director
Susan Howard

Independent Monitoring Board chair
Dr Vyra Navaratnam

Date of last inspection
23 October–3 November 2017

Section 1 Summary of key findings

1.1 We last inspected HMP & YOI Rochester in 2017 and made 46 recommendations, five of which were about areas of key concern. The prison fully accepted 38 of the recommendations and partially (or subject to resources) accepted six. It rejected two of the recommendations.

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

Progress on key concerns and recommendations from the full inspection

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

1.4 At our last full inspection, we made two recommendations about key concerns in the area of safety. At this inspection we found that one of those recommendations had been achieved and one had been partially achieved.

1.5 We made one recommendation about key concerns in the area of respect. At this inspection we found that this recommendation was no longer relevant.

1.6 We made one recommendation about key concerns in the area of purposeful activity. At this inspection we found that this recommendation had not been achieved.

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

Outcomes for prisoners

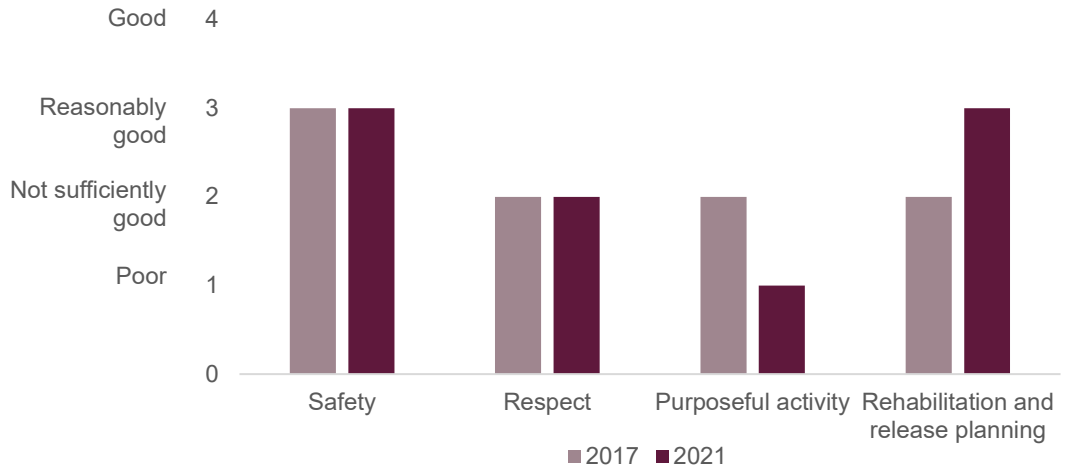
1.8 We assess outcomes for prisoners against four healthy prison tests (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.9 At this inspection of HMP & YOI Rochester, we found that outcomes for prisoners had stayed the same in two healthy prison areas, improved in one and declined in one.

1.10 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 Rochester healthy prison outcomes 2017 and 2018



Safety

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

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

1.11 Reception procedures were carried out well and prisoners were treated with respect on their arrival at Rochester. However, the first night safety interview needed to be confidential and new arrivals might have benefitted from structured peer support during their early days in custody. The first night cells we looked at were clean and well prepared but induction to the prison and the regime were poor.

1.12 Most prisoners at Rochester felt safe. Rates of violence were similar to the previous inspection, but fewer incidents were serious. The prison did not undertake any detailed analysis of the causes of violence to inform future planning. The safety intervention meeting was ineffective, but good support was provided to a small number of prisoners through complex case reviews. The current regime did little to promote good behaviour.

1.13 Too many adjudication cases did not proceed, some of which involved serious offences. Force was used frequently, but levels were similar to comparable prisons. Governance arrangements with respect to the use of force were reasonably good. Use of the segregation unit was high, but over half of prisoners segregated were there pending adjudication. Segregation staff knew the prisoners in their care well, and the unit was

settled. The regime was poor and little attention was paid to reintegration planning.

1.14 Intelligence reports were analysed, collated and disseminated well. Inter-agency work to manage staff corruption, gangs and extremism was good. Managers were aware of the key threats to the prison, one of which was the availability of drugs. Despite this threat, there was still no mandatory drug testing, and more than a third of target searches could not proceed due to staff shortfalls.

1.15 There had been one self-inflicted death since the previous inspection and the prison acted promptly to implement the Prisons and Probation Ombudsman's recommendations. The rate of self-harm had declined since the previous inspection and was lower than at other category C prisons. Assessment, care in custody and teamwork (ACCT) case management documentation for prisoners at risk of suicide or self-harm was generally completed to a reasonable standard and prisoners said they received good care from staff. However, their daily regime was usually poor, and they had limited access to some of the interventions recommended for their care, including Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners). There was insufficient effective data analysis of self-harm, and the prison did not have a robust plan to deal with potential rises in levels once COVID-19 restrictions are eased.

Respect

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

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

1.16 In our survey, fewer prisoners than at the previous inspection said staff treated them with respect. During our inspection, we observed some positive interactions, but little effective key work (see Appendix II Glossary of terms) had taken place in recent months. Only a limited number of prisoners had been allocated to meaningful peer support roles.

1.17 Cells in the older accommodation were dilapidated and in need of continual repair. The newer accommodation was marginally better, and cells were equipped with in-cell showers. Rodent infestations persisted despite efforts to address the problem. Communal areas were clean and tidy, and most outside exercise areas were equipped with exercise machines. Despite evidence from numerous complaints, applications and Independent Monitoring Board reports, prisoners still experienced problems accessing their stored property. The food was reasonably good, and most wings had microwaves, a toaster and a fridge.

1.18 Prisoner consultation arrangements were in place and the main forum was reasonably good. Applications from prisoners were not tracked or

overseen, and some remained unanswered for over a month. Many of the complaints submitted were upheld, which indicated that they were properly investigated. However, we also found too many responses that were unhelpful. Trends in complaints were monitored but had not led to improvements in areas such as property management.

1.19 Work to promote equality was reasonably good. Consultation with prisoners with protected characteristics was developing and had led to improvements in outcomes for some. Responses to discrimination complaints were generally satisfactory, but too many were delayed. In our survey, prisoners in most protected groups had broadly similar views, except for Muslim prisoners who were more negative about how staff treated them. Interpretation services were used to communicate with non-English speakers. Staff demonstrated a good awareness of prisoners who had personal emergency evacuation plans, but the day-to-day treatment of prisoners with physical disabilities was not monitored well enough. Those transitioning from the youth estate and care leavers (a person aged 25 or under, who has been looked after by a local authority) received good support. The chaplaincy had also continued to support prisoners throughout the pandemic.

1.20 Partnership working between health providers, Public Health England and NHS Commissioners was good. Processes in place to manage a COVID-19 outbreak and the vaccination programme were effective. However, clinical governance systems and processes were not robust. Not all incidents were being reported which meant that risks, trends and themes to identify gaps in patient care were not identified.

1.21 Primary care services were well led and the team provided a good quality service. This was hampered by the inadequate clinical space and some waiting lists were too long. Access to external hospital appointments was limited to four days per week to accommodate operational staff shortfalls.

1.22 Mental health and substance misuse services were delivered by dedicated and experienced teams. All patient assessments took place on the wings but confidential and therapeutic space was not always available which wasted clinical time, delayed care and contributed to long waits for therapeutic interventions.

Purposeful activity

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

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

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 5.

1.24 Most prisoners spent over 22 hours locked in their cells each day and too few prisoners took part in any form of purposeful activity either remotely or face to face.

1.25 Gym staff were quick to introduce outside sessions when the pandemic began and reopen the sports hall once restrictions permitted. However, most prisoners could only attend once or twice a week, and some could not attend any sessions. The library remained closed.

1.26 Progress towards delivering a full education, skills and work curriculum had been too slow. Teachers had made suitable plans to reintroduce classroom and workshop teaching, but the expansion of the provision was limited by ongoing staff shortages.

1.27 The number of prisoners who had participated in in-cell education was extremely small. Most in-cell packs were of a suitable standard and the majority seen by inspectors had been appropriately marked. A small number of prisoners achieved their certificates in mathematics and information and communications technology.

1.28 Leaders continued to work with businesses to develop training opportunities within the prison, such as in roofing or events stewarding.

1.29 Managers had not sufficiently prioritised digital learning, and prisoners were not developing the vital digital skills they needed to support their resettlement. Prisoners' involvement with careers advice and guidance workers was limited to the short time prisoners spent out of their cells and had a limited impact.

1.30 The induction to education was not effective enough and did not meet prisoners' needs. Prisoners undertook induction and initial assessment activities unsupported in their cells, because of the requirement to self-isolate on arrival at the prison.

1.31 In the few sessions we could visit, prisoners were engaged, attentive and pleased to be with their peers, teaching staff and instructors.

Rehabilitation and release planning

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

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

1.32 Social visits had resumed in May 2021, and video calling was available, but staffing shortages limited the availability of both. Visiting sessions were only available for 45 minutes, the minimum that the prison was permitted to deliver under stage 3 of the national framework for prison regimes and services (see paragraph 1.10.) National charity Spurgeons continued to provide support to prisoners and their families. Prisoners

valued their in-cell phones, which enabled them to stay in touch with family and friends.

1.33 An up-to-date reducing reoffending strategy document was in place, but there was no action plan, and only two meetings to drive the delivery of the strategy had taken place since the start of the pandemic. Caseloads for prison offender managers (POMs) were reasonable and levels of contact between them and prisoners were sufficient to promote progress in the majority of cases we inspected.

1.34 The offender assessment system report backlog was small. Most of the prisoners whose cases we examined in depth had sentence plans that were at least of a reasonably good standard, and some were very good. In just over half of these cases, prisoners had also made sufficient progress against their plans.

1.35 Home detention curfew processes were generally sound, but too many were released after their eligibility date. Release on temporary licence remained suspended, despite the high number of category D prisoners.

1.36 In the prisoner cases we reviewed, up-to-date risk management plans were in place in virtually all cases and were of reasonable quality. Work on managing the risks of those within a few months of release was also good. Public protection monitoring arrangements were weak and there was a large backlog of calls waiting to be monitored.

1.37 A substantial number of category D prisoners (90) had not yet been transferred to open conditions, and they were not being provided with a regime that was suited to their reduced risk level.

1.38 Some offending behaviour programmes had been delivered in the previous 12 months, but with significantly reduced prisoner numbers. Waiting lists for courses continued to rise and a large number of prisoners were likely to be released from custody without having completed interventions to address their offending behaviour. Some POMs had undertaken meaningful face-to-face, offence-related work with prisoners who were unable to take part in accredited programmes.

1.39 We found good evidence of POMs liaising with external community offender managers to confirm resettlement plans. Assistance and advice were available for prisoners approaching release. Key resettlement partners had all now returned to the prison and were seeing prisoners face to face. Data supplied by the prison indicated that in the previous 12 months, 86% of prisoners had sustainable accommodation on their first night of release.

Key concerns and recommendations

1.40 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.

1.41 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.

1.42 Key concern: There were weaknesses in the support provided to new arrivals. First night interviews did not assess prisoners' immediate risks and vulnerabilities thoroughly enough to ensure that staff could provide appropriate support. The regime on the reverse cohorting units was poor, which limited opportunities for staff to identify prisoners at risk of self-harm. There was no formal induction programme, and prisoners did not have access to Listeners or other peer workers to help them understand what to expect from their early days in custody, or how to access sources of support.

Recommendation: Safeguards should be in place to ensure that all prisoners arriving at Rochester are kept safe, including a thorough risk assessment of their needs, and have access to relevant information and proactive support from staff and peer workers during their early days in custody. (To the governor)

1.43 Key concern: Rates of attrition and staff shortfalls impacted on the prison's ability to deliver a full regime. Drugs were identified as a key threat but there were insufficient staff to carry out mandatory drug testing and target searching. External hospital appointments were restricted, and some were cancelled. The prison could not deliver enough courses to meet the needs of the population. Staffing shortfalls were likely to delay progress to a full regime until at least spring 2022.

Recommendation: There should be clear measures to recruit, train, and retain operational staff to keep prisoners safe and healthy and deliver a full rehabilitative regime. (To HMPPS and the governor)

1.44 Key concern: There were weaknesses in the prisons' approach to maintaining safety. The policy was out of date, data was not analysed to determine the risks of rising violence and self-harm as restrictions eased and there were no plans to counteract these risks. There were few proactive interventions to manage the perpetrators of violence and little support for victims. There were no arrangements for logging or monitoring referrals made to the safer custody team and we found one case of bullying that was not acted on for this reason.

Recommendation: The strategy to improve safety outcomes should be informed by good data analysis and include an effective action plan to reduce violence and self-harm. (To the governor)

1.45 Key concern: In our survey significantly fewer prisoners than last time said staff treated them with respect (66% compared with 78%). Limited time out of cell restricted the time available for positive relationships to develop. Staff had little time to help prisoners with day-to-day issues. Key work duties were cancelled which compounded this problem. There was no evidence of key workers supporting prisoners on ACCT case management or challenge, support and intervention plans.

Recommendation: Staffing levels and prisoners' time out of cell should be increased to facilitate the development of productive and positive relationships. (To the governor)

1.46 Key concern: The cells in the older accommodation blocks were dingy and dilapidated and in need of continual repair, leaking plumbing was commonplace, and in some cells the electricity wiring appeared to be in a dangerous state. There was an ongoing problem with a rodent infestation that affected most prisoners. None of the single cells had toilet screens, which was undignified. Most windows across the prison needed to be repaired or replaced as the ventilation hatches could not be opened, which meant it was difficult to regulate the temperature in the cells.

Recommendation: Cells in the older part of the prison should be taken out of commission and refurbished or replaced to ensure that all prisoners live in cells that are safe, decent and comfortable. (To the governor and HMPPS)

1.47 Key concern: Prisoners told us about problems accessing their stored property, and, in 2021, almost a third of all complaints related to the issue. There were delays in processing property and answering prisoners' queries, leading to frustration. Records were not always complete, which meant it was not possible to find items. Some prisoners waited months to receive items sent in by post.

Recommendation: Prisoners should have ready access to their stored property. Requests for access should be dealt with within agreed and published time scales following consultation with prisoners. (To the governor and HMPPS)

1.48 Key concern: Clinical governance systems and processes were underdeveloped across primary care and dental services. This included the management of complaints, infection prevention and control oversight and learning lessons from incidents. We were not confident that factors affecting patient safety were identified or addressed in a timely manner.

Recommendation: Robust governance procedures, including consistent incident reporting and investigation, should be implemented to ensure that concerns affecting patient safety are promptly addressed. (To the governor)

1.49 Key concern: Most prisoners were locked in their cells for over 22 hours a day, with little to keep them occupied, which was having a detrimental effect on their well-being. The prison had been slow to expand the regime, partly because of staff shortages. The prison did not have a clear plan for a complete regime recovery.

Recommendation: All prisoners should have adequate time out of cell to participate in a regime that includes purposeful activity, time to complete domestic chores and the opportunity to socialise with their peers. (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 four examples of notable positive practice during this inspection.

1.52 Spurgeons charity had been particularly innovative in finding ways to support prisoners and their families during the pandemic. Initiatives included working with local community charities to strengthen fathers' ties with their new-born babies and supporting families with financial difficulties by providing basic items, such as toiletries and baby products. (See paragraph 6.8.)

1.53 All POMs received regular formal supervision. To inform these sessions, they completed a 'delivery report' in advance, which was a simple but effective way to record the work they had done, provide assurance to managers, and stimulate useful discussion during supervision. (See paragraph 6.14)

1.54 Many POMs had been allocated the responsibility for developing expertise and knowledge in specific thematic areas, for example, care leavers, mental health and foreign nationals. They provided the OMU with a point of reference. (See paragraph 6.15.)

1.55 A care leaver specialist from Kent County Council visited the prison to advise and support care leavers, which promoted good partnership working and helped with effective release planning. (See paragraph 6.21.)

Section 2 Leadership

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

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

2.2 Leaders and partner agencies had been proactive and effective in minimising the risks of COVID-19, and compliance with safety procedures was good. The prison had experienced one outbreak of the virus, which had been handled well.

2.3 The prison's self-assessment report set out clear priorities that aligned with our findings during the inspection, such as the need to reduce violence and improve living conditions. However, leaders did not include a priority to improve recruitment and retention even though staffing shortfalls were impacting negatively on the delivery of important work. In the staff survey, most respondents knew what the priorities for the prison were, and some staff we spoke to could broadly articulate them.

2.4 Senior officers had been reinstated as wing managers and along with proactive custodial managers and senior leaders, the leadership team was visible in residential areas.

2.5 Although leaders had obtained investment and made efforts to maintain the prison, the environment was run down, and accommodation was dilapidated. Nationally, leaders were developing a credible redevelopment plan to address accommodation problems in the long term. However, at the time of the inspection, and for the foreseeable future, prisoners at Rochester were living in poor conditions.

2.6 Moderate levels of violence and a reduced rate of self-harm were attributed to the safety provided by restricted regimes rather than the implementation of a data-informed strategy. Given that the prison would have to ease current restrictions to fulfil its rehabilitative purpose, this presented a potential risk. Leaders had identified the risk of levels of violence and self-harm rising as the regime recovered, but there was little detailed planning to prepare for recovery and more normal regimes. The prison collated some good data, but senior managers had not used them to inform future strategies.

2.7 Eighteen months into the pandemic, the prison's priority of stopping the spread of COVID-19 seemed out of balance with insufficient attention given to other priorities such as the need to engage with and rehabilitate prisoners. Leaders had not, for example, used the regime

or the variety of wings available creatively to motivate prisoners or develop a clear pathway for progression. There were pockets of innovative work, and interventions were delivered to a small number of prisoners, but not enough to meet the needs of most.

2.8 Ofsted concluded that there had been insufficient progress in learning and skills. Leaders aimed to return to a more purposeful regime as soon as possible, but progress was slow. Plans to increase the number of activity spaces would still only provide work and education for less than half the population.

2.9 Leaders had established effective partnerships with the local police and Kent County Council. Relationships with the main partners were healthy but did not always lead to improved outcomes: Healthcare leads had not been involved in recovery planning and there was no capacity within the next stage to implement nurse-led clinics or return to agreed number of escorts for hospital appointments. Despite joint working, leaders were making insufficient progress in delivering a full curriculum and providing support to meet learners needs. GFSL were engaged and proactive but the volume of outstanding repairs still meant that living conditions were poor.

2.10 Proposals outlining a return to a full regime were limited and staffing shortfalls were likely to delay progress until at least spring 2022. Other prisons at the same stage of recovery were delivering more, suggesting a lack of ambition in what was otherwise a stable category C prison, in which everyone had been offered the COVID-19 vaccination. There was a lack of clarity behind some decisions: for example, why cohorts could mix for some activities but not others. It was also difficult to determine the reasons for the lack of progress – leaders' arguments fluctuated between the need to preserve life, staff shortages, and instructions from HM Prison and Probation Service. Moving to the next stage of recovery while rates of attrition and staff shortfalls were so high presented a significant leadership challenge.

Section 3 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

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

3.1 Rochester received an average of 16 prisoners each week, and most arrivals were transferred from other prisons in the region. Prisoners waited for a short time on the vans before walking into the reception area with staff. They were not routinely handcuffed, which was a proportionate response to the risk posed.

3.2 Once in reception, prisoners were welcomed by staff, and we observed that they were treated respectfully. Our survey also found that 86% of prisoners said they were treated well in reception. While the reception area and holding cells were clean and functional, we found there was too little advice or guidance for arrivals. Information about daily life at the prison displayed on the wall of the main holding cell was out of date, and prisoners could not speak to a Listener because of COVID-19 restrictions. In addition, there were no peer workers to put prisoners at ease, offer support or provide information about what to expect at the prison. A reception orderly assisted staff with some tasks but did not interact with prisoners. (See key concern and recommendation 1.42.)

3.3 While in reception, prisoners received a rub-down search and were placed in the body scanner. They were not routinely strip-searched. All prisoners had a health care interview and a first night safety interview in reception. First night interviews were conducted in an office with the door open and lacked privacy. Staff told us this was for safety reasons, but we observed that the health care interviews were conducted with the door closed. The first night interview lacked depth, which meant that prisoners' needs, concerns or risks might not have been identified or disclosed. (See key concern and recommendation **Error! Reference source not found.**.)

3.4 Staff typically searched and recorded prisoners' property in front of them as part of the reception process. However, during busy periods, they would sometimes process prisoners' property the following morning.

3.5 In our survey, only 45% of prisoners said they spent less than two hours in reception – our observations supported this view. New arrivals stayed in the holding room until everyone had completed the reception

process, and they were then taken to the reverse cohort unit (RCU) together. As a result, prisoners often spent too long in reception. Before being taken to the RCU, prisoners were given a cold lunch pack and basic items like vape kit, a kettle and toiletries, but they could not have a shower while they were in reception.

3.6 Most prisoners spent at least 10 days (and an average of 17 days) in the RCU, sharing double cells, which had an in-cell shower and phone. RCU cells we inspected were clean and appropriately equipped before use, although at the time of our visit, R wing had run out of duvets and at least one prisoner went without one on his first night.

3.7 In our survey, 82% of prisoners said they felt safe on their first night in the prison. Wing staff knew who the new arrivals were and where they were located. In our survey, 91% of prisoners in the RCU said that staff treated them with respect, which was higher than the general population at Rochester (61%), while 100% said that the RCU wings were clean, compared with 65% of prisoners elsewhere in the prison.

3.8 The full induction programme had been suspended at the start of the pandemic and had still not resumed. In our survey, only 68% of prisoners said they had received an induction, fewer than at our previous inspection (94%). Of those who had received an induction, only 39% said that it told them everything they needed to know about the prison. Prisoners received a brief induction booklet, which outlined the regime in the RCU, as well as some basic information about the prison. (See key concern and recommendation **Error! Reference source not found.**.)

3.9 On their second day, prisoners received a second health care visit. They also told us they had received a visit from a member of the chaplaincy.

3.10 The regime in the RCUs was inadequate. Prisoners could only associate with peers who had arrived at the same time as them for at least the first 10 days. They had a maximum of 1.5 hours out of their cell every day, and did not have access to the gym, or to education or work opportunities.

Managing behaviour

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

Encouraging positive behaviour

3.11 In our survey, 14% of prisoners said they felt unsafe at the time of the inspection, which was about the same as at the previous inspection and similar to comparator prisons. Only 27% of prisoners said that they

would report being bullied or victimised by other prisoners and 29% said staff had verbally abused them.

3.12 Recorded incidents of violence were similar to those at the previous inspection. Prisoner-on-prisoner violence had declined but assaults on staff had increased. However, there had been a decrease in the number of serious assaults to six in the 12 months before this inspection, from 28 in the same period before the previous inspection. Most prisoner violence against staff was related to non-compliance, and prisoner-on-prisoner violence was due to retaliation, drugs and debt.

3.13 The prison's strategic approach to managing and reducing violence was weak. There had been no analysis of the causes of violence and no prisoner consultation to inform future planning. The safety policy was out of date, largely procedural and not specific to the prison, which meant there was little focus on the key issues at Rochester. (See key concern and recommendation 1.44.)

3.14 The safer custody team met every month, but there was little analysis of available data or in-depth discussion about plans to reduce violence. The referral process for assessing if prisoners should be managed using challenge, support and intervention plans (see Appendix II Glossary of terms) was used well. The sample of investigations into violent incidents that we reviewed showed that inquiries were mostly reasonable, but violence was usually dealt with using the incentives and earned privileges (IEP) scheme and standard disciplinary procedures. There were few proactive interventions to manage perpetrators and minimal support for victims of violence. We also found an example of a prisoner who stated that he was being bullied. Although the information was submitted to the security department and disseminated to the safer custody team, it had not been acted on as there were no arrangements for logging or monitoring referrals made to the department. Prisoners in need of additional support might therefore not receive it.

3.15 A weekly safety intervention meeting aimed to manage prisoners who were identified as posing a concern. However, we found it to be brief, ineffective and lacking in focus, increasing the likelihood that those who needed structured support would be overlooked. Records did not provide sufficient evidence of meaningful discussion or action. There was also a separate forum called the complex case meeting which provided good support to a small number of prisoners with significant needs (see paragraph 4.90). There was no specific criteria for deciding who was a complex case and it tended to be prisoners who did not fit neatly into a particular category such as those on an ACCT or CSIP. It was not clear why there had to be two separate meetings.

3.16 Many prisoners told us there was little to influence their behaviour or motivate them to participate in the regime. Leaders had not created a clear pathway for progression (see paragraph 2.7). An interim IEP policy was in place, focusing mostly on action against those who did not comply rather than rewarding prisoners and encouraging them to

progress through their sentence. The policy also allowed staff to remove prisoners' televisions and restrict their regime without formal supervision or oversight, which was not appropriate.

Recommendation

3.17 **Rewards and sanctions should motivate prisoners to participate in the regime and support their progression.**

Adjudications

3.18 There had been 1940 hearings in the previous 12 months. The number of adjudications that did not proceed or that were dismissed due to procedural errors was high (19%). Among them were allegations of assault, possession of mobile phones and fights, which meant some serious offences were committed without consequence.

3.19 The completed adjudication records that we sampled showed that most prisoners were given enough time to prepare and request legal assistance, and sufficient investigations were carried out before a finding of guilt.

3.20 Useful data about adjudications were collated and presented to the segregation monitoring and review group, but there was a lack of clear action planning when issues were identified. For example, the high level of adjudications that did not proceed had been identified repeatedly, but no action was taken to reduce it.

Recommendation

3.21 **Action to address issues identified at the segregation monitoring and review group should be specific, measurable and time bound to make sure that the process deals with the most serious offences effectively.**

Use of force

3.22 HM Prison and Probation Service data showed that force was used more frequently than at the previous inspection and the number of incidents requiring force was continuing to trend upwards. Despite this, the total number of recorded incidents (361) over the previous 12 months was comparable to other similar prisons. Most incidents (88%) were spontaneous and unplanned.

3.23 Governance arrangements were in place. Quarterly use of force meetings made good use of available data; including the reasons force was used. In addition, a monthly scrutiny meeting analysed a sample of incidents involving force from the preceding month. However, even the most serious incidents were not reviewed until this meeting, which created an unnecessary delay in action to address any identified failings.

3.24 Although governance arrangements had improved since 2017, local scrutiny lacked sufficient rigour to assess whether the force used was

necessary or proportionate. Our analysis of a random sample of incidents highlighted concerning practices, such as the unjustified use of pain inducing techniques, and force not being used as a last resort. These issues had not been identified through local scrutiny and the poor practice was not addressed. We raised our concerns with managers, but we were not assured that the issues were dealt with appropriately.

3.25 The use of special accommodation had declined since our previous inspection and was infrequent. In the 12 months before our inspection, it had been used on three occasions. Prisoners remained in special accommodation for an average of 110 minutes. Documentation to justify the use of special accommodation was only available in two cases, but our judgement was that only one was clearly justified based on the recorded information made available. Documentation for the other case demonstrated that the prisoner had been calm for approximately an hour but was not returned to their cell at the earliest opportunity.

Recommendation

3.26 **Quality assurance procedures should be sufficiently robust and thorough to make sure all incidents where force is used are justified, proportionate and only used as a last resort.**

Segregation

3.27 There had been 437 uses of segregation in the previous 12 months which was high. Of these prisoners, 52% were awaiting adjudication, which was too many. In our survey, 63% of those who had been segregated said staff had treated them well. Strip-searching was routine for all prisoners who were moved to the segregation unit, and not normally based on an individual risk assessment.

3.28 The segregation unit was quiet, had lots of natural light and staff we spoke to knew the prisoners in their care well. As at the previous inspection showers were in a poor state of repair. Exercise yards were bleak and cage-like, although one yard had been improved with the addition of exercise equipment.

3.29 The regime was inadequate, and time out of cell was restricted to 30 minutes' exercise, a phone call and a shower. In our survey, only 58% of prisoners who had been segregated said that they could have a shower every day. Before our inspection, prisoners were expected to choose two out of their three entitlements every day because staffing shortages made it difficult to accommodate the full regime for all. This meant most prisoners did not have a shower. This was rectified when we brought it to the attention of leaders.

3.30 The documented reasons for segregation were generally adequate but behaviour targets were generic, and health care staff did not always attend segregation reviews. Little attention was paid to reintegration planning and objectives were not tailored to the prisoner.

3.31 Some useful data was gathered and presented at the segregation monitoring and review group, but it was not clear how this information was used to effect change. For example, on several occasions, staff had said there were some delays in health care professionals completing safety screenings when prisoners were segregated, but it was not clear what action had been taken to address the problem. There were also no plans to minimise the use of segregation for those pending adjudication.

Recommendations

3.32 **As a minimum, prisoners should be able to have a shower, make a phone call and spend time in the fresh air every day.**

3.33 **Health care staff should attend all segregation reviews.**

3.34 **Target setting in segregation paperwork and reintegration plans should be meaningful and tailored to the individual.**

3.35 **Prisoners should only be segregated pending adjudication if they pose a significant risk.**

Security

Expected outcomes: Security and good order are maintained through an attention to physical and procedural matters, including effective security intelligence and positive staff-prisoner relationships. Prisoners are safe from exposure to substance use and effective drug supply reduction measures are in place.

3.36 Physical security arrangements were broadly proportionate. However, some procedural security plans being considered risked being disproportionate and not conducive to the rehabilitative ethos of a category C prison. For example, the prison was considering escorting all prisoners to appointments instead of managing an effective appointment system where prisoners were trusted to attend meetings with the doctor or their offender manager by themselves. This was in response to a small number of prisoners who had abused the system in the past.

3.37 Two security meetings were held each month – one was an overarching local threat assessment meeting, which identified current risks and considered the prison's response at a strategic level. A local threat briefing was then produced to inform the monthly security committee meeting. However, records from the monthly security meetings did not always identify appropriate action to address the threats. For example, the suspension of mandatory drug testing (MDT) or the failure to carry out sufficient target searching was not considered, despite drugs having been identified as a key threat.

3.38 The flow of intelligence into the security department was good. There had been 6684 intelligence reports submitted in the 12 months prior to

the inspection. They were mostly processed promptly, leading to swift action, much of which resulted in positive outcomes.

3.39 Many targeted searches led to illicit items being found. In the 12 months prior to inspection searches across the prison had led to the recovery of 109 mobile phones, 124 drug finds, 34 weapons and 117 alcohol finds. However, staffing shortages and the inability to carry out all requested searches undermined the process. In the 12 months before the inspection, 715 target searches had been requested but only 428 were carried out.

3.40 In our survey, 23% of prisoners said it was easy to get drugs at Rochester. Technology was used well to enhance safety and support the reduction of illicit items. The prison made effective use of a machine to detect drugs entering the prison through the mail and the body scanner to detect and deter the trafficking of illicit items. A joint team involving the police and HMPPS conducted an assessment of drug supply at the prison. Their report included a number of recommendations to reduce supply, some of which had been implemented. However, the drug strategy was out of date and MDT had not taken place since May 2021 – we were told this was due to staffing issues.

3.41 Links with the police were good, and police intelligence officers worked well with the security team. Inter-agency work took place to manage gangs and to identify extremists and those involved in County Lines (where illegal drugs are transported from one area to another). Work to tackle staff corruption was good. Prison managers worked effectively with the police when staff wrongdoing was suspected, and there had been some positive results.

Recommendation

3.42 **Security meetings should lead to clear action plans that are specific, measurable and time bound to reduce the security risks facing the prison.**

Safeguarding

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

Suicide and self-harm prevention

3.43 Since the previous inspection, there had been one self-inflicted death, in 2018. After a Prisons and Probation Ombudsman (PPO) investigation, the prison produced an action plan, and implemented its recommendations promptly.

3.44 The rate of self-harm had decreased by about 14% since the previous inspection and was lower than at other category C prisons. However, it had been rising steeply in the months leading to the lockdown at the end of March 2020. Leaders attributed the lower levels of self-harm to the restricted regime, which reduced the risk of prisoners being exposed to violence and debt. However, they had not undertaken any analysis to support this assertion, and our survey findings about safety did not mark a significant change in perceptions (see paragraph 3.11).

3.45 Senior managers did not have a robust plan setting out how they would further reduce the rate of self-harm as the regime restrictions lifted over the following months. They did not routinely analyse self-harm data, resulting in a lack of understanding of the root causes or patterns. For example, leaders attributed too much self-harm to prolific self-harmers, even though their data indicated wider causes. The prison's response to reducing self-harm was mostly reactive. Wing staff and managers demonstrated a good knowledge of individual prisoners with a history of self-harm.

3.46 During our inspection, we spoke to a number of prisoners at risk of suicide or self-harm who had received support through the assessment, care in custody and teamwork (ACCT) case management system. Most told us that they felt well cared for by staff at the prison. However, in our survey, only 22% of prisoners who had been on an ACCT said the same. The daily regime for prisoners on an ACCT did not adequately support well-being. Access to some recommended interventions, for example off-wing employment or group therapy, was limited by regime restrictions (see also paragraph 4.89).

3.47 The ACCT documentation we looked at was generally completed to a reasonable standard, with most demonstrating adherence to required observations and supportive conversations. We also found a small number of ACCTs that were opened for inappropriate reasons. For example, one document we reviewed was opened at the request of a nurse to enable regular observations to take place for health care reasons rather than because there was a risk of self-harm.

3.48 ACCT reviews were multidisciplinary, but sometimes attendance was low, especially by health care staff, and prisoners' families were not routinely involved in the process. Although ACCT quality assurance identified issues, such as the fact that management checks did not always take place, recommended and necessary improvements were not implemented.

3.49 There were too few Listeners to provide effective support for the population, and access to them was poor. In our survey, only 14% of prisoners said it was easy to speak to a Listener, and Listeners themselves told inspectors they had not been able to fulfil their role and support prisoners in crisis since January 2021.

Protection of adults at risk (see Appendix II Glossary of terms)

3.50 During the inspection, there was confusion over which senior manager was responsible for safeguarding. Although leaders told us that the prison was represented at the local authority safeguarding board on a regional basis by the governor of HMP Elmley, it was unclear how outcomes were fed back to HMP Rochester.

3.51 A safeguarding self-assessment, dated November 2020, had been completed to a good standard and identified some action to improve safeguarding procedures. However, there appeared to be a lack of oversight of this document, and there was no record of who was responsible for implementing the action, to what timescale, or whether it had already been completed. Staff we spoke to were unfamiliar with formal safeguarding procedures, which increased the risk of prisoners' needs being overlooked.

3.52 We also found evidence of prisoners' social care needs not being met. (See paragraphs 4.83 and 4.84.)

Section 4 Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

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

4.1 In our survey, far fewer prisoners than at the previous inspection said staff treated them with respect (66% compared with 78%). Only 25% of respondents said a member of staff had spoken to them about how they were getting on in the previous week.

4.2 During our inspection prisoners spoke more positively about staff, and we observed many good-natured and respectful interactions throughout the prison. However, the restricted regime (see paragraphs 5.1 and 5.4) limited staff's opportunities to speak to prisoners. Some told us that staff did not have time to deal with day-to-day problems, and they had to rely on submitting applications or complaints to get the help they needed (see paragraph 4.25). (See key concern and recommendation 1.45.)

4.3 Prisoners' frustrations were exacerbated by the fact that very little key work had been undertaken in the previous six months. Key workers (see glossary) recorded sessions with prisoners on P-Nomis (a database used in prisons for the management of offenders). Often an entry was made simply to record the fact that a session had not taken place, yet the data were still interpreted as if a key work session had taken place. This meant leaders were not aware of the full extent of the problem. To take one example, of the 60 key work entries recorded for a prisoner over a 12-month period, only seven sessions had actually taken place. (See key concern and recommendation 1.45.)

4.4 Officers stated that they would only conduct a session when scheduled to do so, and even if a prisoner on their caseload lived on the wing where they worked, they would not conduct ad-hoc sessions. We found no evidence of key workers supporting prisoners on an assessment, care in custody and teamwork (ACCT) document or with a challenge, support and intervention plan, and there was little evidence of key work being linked to prisoners' sentence progression. It was encouraging, however, that the senior probation officer had developed a training package for middle managers to improve the quality of key work. (See key concern and recommendation 1.45.)

4.5 Since the implementation of a restricted regime, opportunities for prisoners to work in peer support roles had significantly declined. Leaders had neglected this area, despite Rochester being a category C

prison, and staff being unable to provide the support needed as consistently as required.

Daily life

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

Living conditions

4.6 Outdoor spaces were tidy and well-maintained, although litter had accumulated under the windows of the older accommodation blocks. Some exercise yards were very small, but they were kept tidy and were fitted with fixed exercise machines.

D wing exercise yard

4.7 Communal areas inside, such as wing landings, created a good first impression. Most of the communal shower blocks in the older accommodation had been refurbished and were noticeably better than those still to be updated.

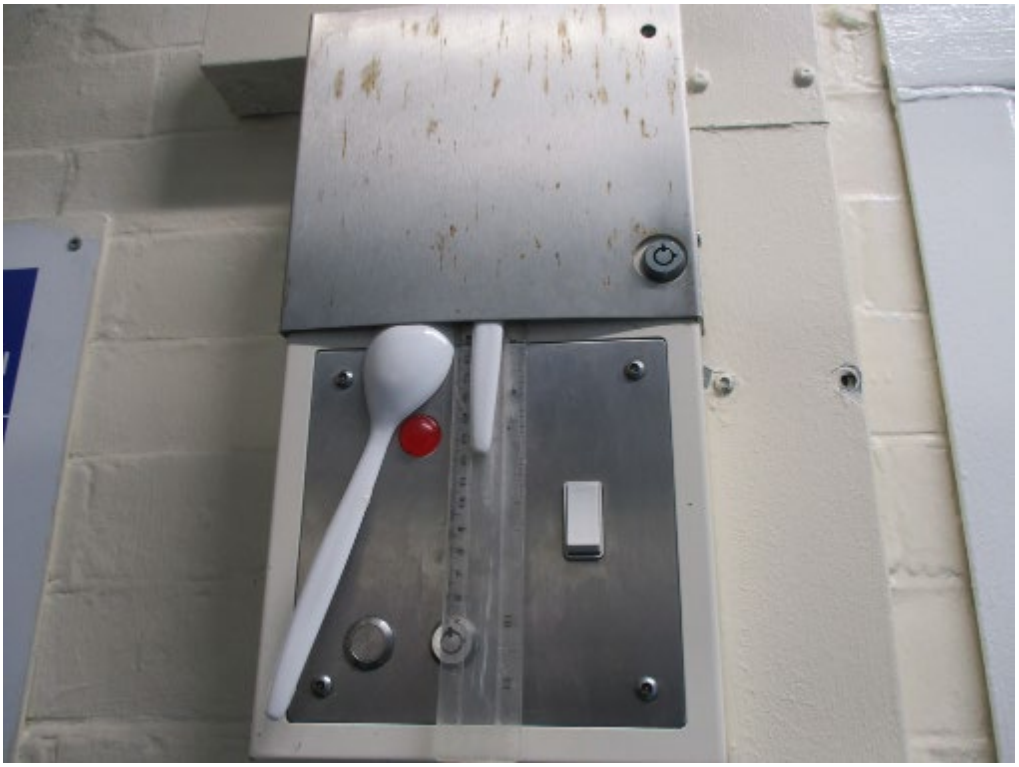
Landing and stairs in older accommodation

4.8 The cells in the older accommodation were dingy and dilapidated, and in need of continual repair. On one day alone during the inspection, 55 jobs were referred to the maintenance contractor. Many of the repairs related to leaking sinks and issues with the toilets. (See key concern and recommendation 1.46.)

Double cell on E wing toilet leaking and undermining flooring

4.9 The prison had a good working arrangement with the contractor whose staff attended the daily meeting. Repairs were generally completed promptly, although issues such as in-cell plumbing took much longer as parts were no longer available. The flooring was peeling in some cells, and while there was an ongoing programme of replacement, it was slow, and prisoners pointed out that they were living with a trip hazard. Some electrical work was not safe, for example, sockets were coming away from the wall exposing the wiring.

4.10 In some cells the only socket to plug a kettle into was on a narrow shelf, high up next to the television. One prisoner told us this precarious arrangement had resulted in him being scalded. Other prisoners told us the electrics regularly tripped, leaving them without power. To overcome this, prisoners had pushed plastic items into the fuse box outside the cell door. (See key concern and recommendation 1.46.)



Plastic items used to prevent electric circuit breaker from tripping on E wing

4.11 Many cells had no curtains. None of the single cells had privacy screens around the toilet, which could be seen from the observation panel, which meant prisoners' dignity was compromised (See key concern and recommendation 1.46.)

Empty cell on B wing, with toilet clearly seen from doorway

4.12 Despite the prison having taken reasonable measures to tackle the issue of vermin, such as appointing a contractor and providing plastic waste bins, almost all prisoners in the older accommodation complained that their cells were infested with mice at night. Some prisoners had purchased plastic containers to prevent their food from being eaten. (See key concern and recommendation 1.46.)

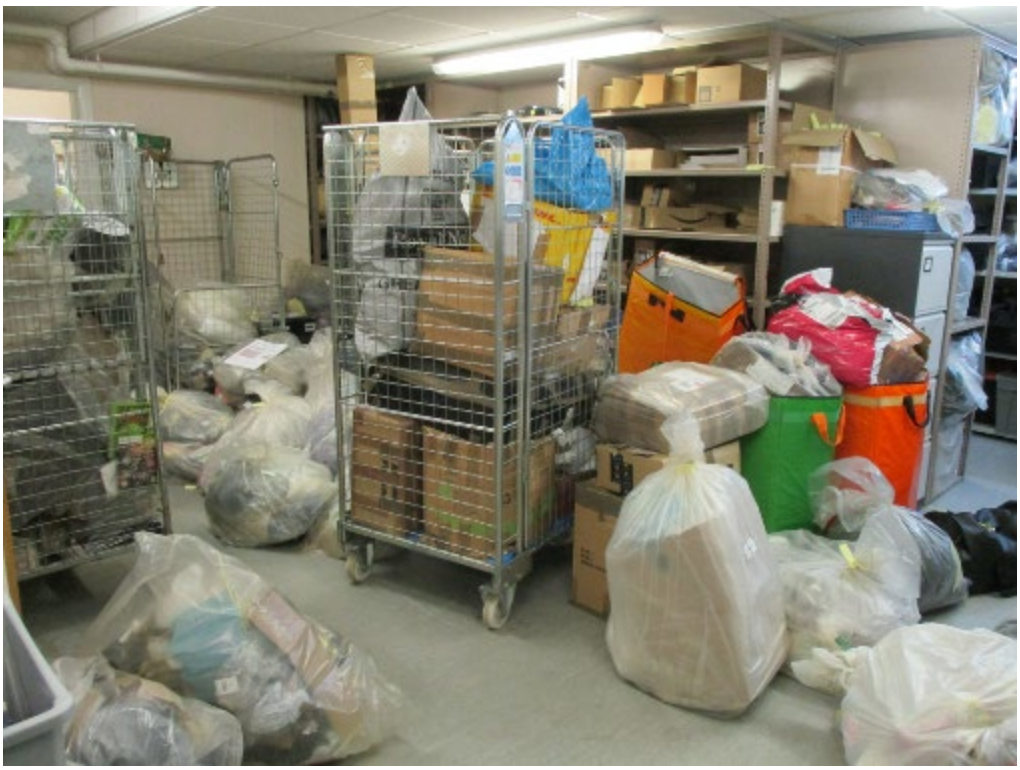
4.13 The newer accommodation was in a better state of repair and prisoners valued the in-cell showers. However, the cells were far too small for two prisoners. Most only had room for one chair, which many kept in the shower to make more space.

4.14 Many cell windows across the entire prison were in need of repair or replacement as the vents were stuck in either the open or closed position. This made it difficult to regulate the temperature inside and cells were either too hot or too cold. (See key concern and recommendation 1.46.)

4.15 Prisoners could wear their own clothes and each wing had a laundry. The laundry on A wing only had two domestic washing machines for 78 prisoners; the plumbing and electrical arrangements appeared to be unsafe.

Electric and water supply in close proximity in laundry room on A wing

4.16 In our survey, only 14% of respondents said they could access their stored property. Problems in property management persisted for some time despite being repeatedly highlighted by the Independent Monitoring Board. Escort companies limited the amount of property prisoners could bring from another establishment to three bags, and it was often weeks before the sending establishments forwarded the remainder of the prisoner's property to the prison. However, even after it had arrived it was not always processed promptly and we saw a huge amount of property on the floor of the property store, some of which was still there a week later. (See key concern and recommendation 1.47.)



Prisoners' property to be sorted in property store

4.17 Hundreds of applications about property had not been dealt with, some of which had been submitted in August asking for property to be handed out on a social visit that month. (See key concern and recommendation 1.47 and paragraph 4.25.)

4.18 Prisoners could have parcels sent in, which were checked in at the property store before being issued. All books, socks and boxer shorts were sent to the post room to be scanned for the presence of drugs (see paragraph 3.40). There was no tracking system for these items. As a result, the prison was not always able to answer prisoners' queries about where their property was, which led to complaints (see paragraph 4.28). We spoke to one prisoner who had made a complaint about not receiving a parcel of books delivered in June; they were eventually handed to him during the week of the inspection. (See key concern and recommendation 1.47.)

Residential services

4.19 The prison offered a four-week menu and the food we saw and tasted was reasonably good. While regular food consultation meetings had been suspended during the COVID-19 restrictions, food was a standing agenda item at the residents' consultation meeting (see paragraph 4.23). Food comment forms were also available on the wings and the catering manager responded to each comment.

4.20 The kitchen and serveries were clean during mealtimes. However, on the wings where evening association was not taking place, servery workers were locked in their cells immediately after the meal had been

served. This meant they did not have enough time to clean the servery and they had to leave dirty food trays until the following morning.

4.21 Prisoners could prepare their own food as each wing had a toaster, microwave and fridge.

4.22 They could purchase a range of items from the prison shop and buy products from a range of catalogues, although we saw order forms in the property store that were dated over a month earlier (see paragraphs 4.16, 4.17 and 4.25).

Prisoner consultation, applications and redress

4.23 In our survey, only 38% of respondents said they were consulted, and only 26% of them said this had led to change. The monthly residents' consultation meeting had resumed in June and was chaired by the governor. The minutes indicated that the meeting did lead to improvements, such as work to fix problems with the National Prison Radio.

4.24 Some wing-based meetings had also taken place, although the minutes did not always show who had attended or whether any action had been implemented as a result. Many prisoners we spoke to were not aware of any consultation arrangements.

4.25 In our survey, prisoners were much more negative than in 2017 about the application process – only 48% thought it was fair compared with 67% at the previous inspection and only 26% said applications were dealt with within seven days, compared with 42% in 2017. Applications were submitted on paper but were not tracked, and we saw some that had remained unanswered for over a month. Many of the applications related to matters that could have been resolved by wing staff. In some instances when prisoners had not received a response to their application, they felt compelled to submit a complaint.

4.26 In our survey, only 30% of respondents said complaints were dealt with fairly and only 16% said they were dealt within the required seven days. At the time of the inspection, 1362 complaints had been submitted during 2021, 878 of which related to issues at Rochester, rather than a prisoners' previous establishment. Almost half of all complaints had been either wholly or partially upheld, which indicated that they were properly investigated and that the prison was prepared to acknowledge that it sometimes made mistakes.

4.27 Managers reviewed the quality of a small number of responses to complaints each month. The prison also had a reciprocal arrangement with HMP Stamford Hill to check a small number of each other's responses. Despite this many of the responses we reviewed were either not helpful or not sufficiently detailed. For example, one prisoner complained of racist and homophobic graffiti in his cell and was told it was not possible to cover it as there was no paint on the wing. We saw some complaints where the prisoner had indicated that discrimination was a factor, but they were either not referred to the equality team or

not recorded as a discrimination incident, undermining the validity of data collected on discrimination (see paragraph 4.38).

4.28 The prison conducted some simple analysis of complaint data each month and senior managers regularly reviewed all complaints about staff. However, there was little evidence that these reviews had led to changes and some common areas of complaint, such as property, remained. In 2021, almost a third of all complaints related to property and over half of them related to other issues at Rochester.

4.29 In our survey, far fewer prisoners than at the previous inspection said they could attend legal visits (28% compared with 49%). The prison had three legal visit sessions each weekday morning and prison data suggested almost two-thirds of these spaces had been booked. Many more prisoners than in 2017 (63% compared with 39%) said their legal mail had been opened without them being present. The prison explained that incoming mail had to be scanned and the process required them to make a small tear in the envelope, which some prisoners construed as mail having been opened.

Recommendations

4.30 **Robust tracking and management intervention should be introduced to ensure the timeliness of responses to applications.**

4.31 **The prison should review the complaint system to make sure that responses are appropriate, allegations of discrimination are properly recorded, and data are analysed to identify and address common themes.**

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 Appendix II 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

4.32 The promotion of equality was underpinned by an equality policy, which set out expectations and described action to take in the event of discrimination. It was accompanied by an annual strategy that analysed ethnic monitoring outcomes. Any concerns that were highlighted in the annual review were incorporated into an equality action plan.

4.33 Although the action plan was comprehensive, it was not clear if follow up action had actually been taken. Some issues had been identified but seemed not to have been addressed, for example, the disproportionate number of complaints from black and minority ethnic prisoners.

4.34 The agenda of the most recent equality action team meeting was comprehensive, and a detailed range of subjects was discussed. The meeting had provided a good overview of monitoring data on prisoners with protected characteristics. However, the prison's own policy required leaders to hold the meeting every quarter to drive the equality agenda. The most recent meeting had been held some nine months before our inspection.

4.35 Senior managers had been assigned to take the lead on each of the protected groups and their role was promoted well across the prison. Part of their role was to consult prisoners from the groups they were responsible for. A total of 10 consultative forums had taken place in the current year, with good outcomes resulting from some. Senior managers had been assigned to take the lead on each of the protected groups and their role was promoted well across the prison. Part of their role was to consult with prisoners on a regular basis. A total of 10 consultative forums had taken place in the current year, with some good outcomes. However, the delivery and effectiveness of consultation was not consistent for all protected groups. The frequency was irregular and for some groups there was no meaningful action in response to issues raised.

4.36 A folder containing useful diversity and inclusion guidance and templates for staff was available in each wing office. The equality team also organised events to mark key cultural and religious celebrations, including Black History Month.

4.37 No equality peer supporters were in place, although potential representatives had been identified and were awaiting security clearance.

4.38 Responses to discrimination incident reporting form (DIRF) complaints were satisfactory and communication with the complainants had improved in recent months. However, DIRF complaints took too long to investigate and too many responses were delayed, even though they were recorded as having been investigated on time. DIRFs were not readily available on wings, which meant prisoners used complaint forms instead, adding to the delays and skewing the data on discrimination. We came across a number of complaints containing an element of discrimination that had not been referred to the equality team or investigated (see paragraph 4.27). There was no quality assurance for DIRF responses from senior leaders or an external scrutiny panel.

4.39 The prison had liaised effectively with community agencies before the pandemic to support equality work and planned to resume contact once COVID-19 restrictions were relaxed.

Protected characteristics

4.40 In our survey, prisoners in most protected groups reported broadly similar treatment and conditions, except for Muslim prisoners. Representing 11.4% of the population according to the prison's data,

they were much more negative about how staff treated them. Only 23% of Muslim prisoners compared with 70% of non-Muslims said most staff treated them with respect. The prison was unaware of this group's negative perceptions.

4.41 Prison data showed that 19.8% of the population was from a black or minority ethnic background. Our survey indicated that only 57% of this group said they could buy products they needed from the prison shop; this had been an ongoing problem. Only one consultation forum had been held with this group, attended by seven prisoners from the same residential wing. The forum was held during our inspection, and we could not assess progress against agreed action. The minutes were brief, and the focus was on Black History Month rather than attempting to find out what their experiences were as black prisoners.

4.42 Approximately 6.1% of prisoners were from a Gypsy, Romany and Traveller background. Two consultation forums had been held in 2021, although only one prisoner attended the most recent forum. Concerns raised by this group had not been acted on. In July, prisoners said they had nobody to represent them on the wings and there were no jobs for Gypsy, Romany and Traveller prisoners on B wing. The position had not changed during our inspection. Prior to COVID-19, the equality team had arranged for a lead member of staff to conduct awareness sessions with staff. The prison committed to resume the sessions in the near future.

4.43 The prison recorded 44 foreign national prisoners, which comprised 6.5% of the population. However, the prison's data were inaccurate as some of the prisoners confirmed they had British nationality. We saw some good support for foreign national prisoners, including the use of interpretation services for immigration matters, as well as ongoing support through a surgery organised by the Kent Refugee Help, a user-led charity supporting refugees and migrants in local prisons. The surgery was helpful as Home Office immigration surgeries did not take place and access to free independent immigration advice was poor. There had been no consultation with foreign national prisoners.

4.44 Staff had a good knowledge of prisoners who had a personal emergency evacuation plan (PEEP) and notices about those on PEEPs were displayed in offices. We were informed that every prisoner subject to a PEEP had a control and restraint handling plan to support safe use of the technique. However, we found no evidence of handling plans, and operational staff were unaware of them. The equality team subsequently delivered handling plans to each wing.

4.45 The day-to-day treatment of prisoners with physical disabilities was inadequate. Only one consultation forum had been held in 2021, during which several queries about daily care were raised, with no effective response. During our inspection, we came across a prisoner with reduced mobility who had had their crutches confiscated by the security department during a cell search. We raised the issue with the prison, but the matter remained unresolved. Another prisoner had been

provided with a wheelchair without footrests, which meant the wheelchair could not be used safely.

4.46 Prison records indicated that only two prisoners identified as gay and a further two as bisexual. Those we spoke to said prisoners were afraid to declare their LGBT status due to potential reprisals. Not enough was being done to make sure prisoners felt safe seeking support. There were no transgender prisoners at Rochester during the inspection and we were unable accurately to assess the support provided to this group.

4.47 About 38 prisoners were under 21. Good support was offered to prisoners transitioning from the youth estate, and for care leavers (see paragraph 6.21). Staff either spoke on the phone with or met those arriving from the youth estate before their arrival at Rochester.

4.48 Support for older prisoners was limited to those who had attended the veterans' focus group. This represented a gap in provision, given the number of older prisoners at Rochester (about 60). The veteran's forum had led to some positive initiatives, such as opportunities to mentor younger prisoners on the Duke of Edinburgh scheme.

Faith and religion

4.49 The chaplaincy continued to support prisoners throughout the pandemic, although communal worship and religious education classes had been suspended for much of the period. While some religious studies classes had started again in August 2021, the team was slow to resume communal worship.

4.50 In our survey, only 58% of prisoners said they could speak to a chaplain of their faith in private, and only 29% reported being able to attend religious services if they wanted to, both of which were significantly lower than in 2017.

4.51 Facilities for corporate worship were suitable. There was a large intricately decorated chapel for Sunday service and a big multi-faith room, which was used for Friday prayers.

4.52 The chaplaincy was well integrated into the prison and the members of the team attended key meetings such as ACCT reviews. There was also evidence of good partnership working with external agencies.

4.53 The chaplaincy provided prisoners with in-cell activity packs throughout the pandemic. Pastoral support was offered to prisoners who had experienced significant life events, such as a bereavement. Good use was made of tablets so prisoners could watch funerals or contact terminally ill relatives.

4.54 The chaplaincy ran Sycamore Tree (a volunteer-led victim awareness programme that teaches the principles of restorative justice), which was being delivered during our inspection. However, the full range of services and support previously available – such as an anger

management course, a prison outreach programme and the official prison visitors scheme – was yet to resume.

Health, well-being and social care

Expected outcomes: Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.

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

Strategy, clinical governance and partnerships

4.56 Effective partnership working took place between health providers, Public Health England and NHS commissioners. The head of healthcare was part of the prison's senior management team, which meant a COVID-19 outbreak and the vaccination programme could be managed effectively.

4.57 Contract monitoring meetings had been suspended, but quarterly reports including those on the health and justice indicators of performance continued to be produced. A monthly quality board meeting was attended by a governor and the head of healthcare, which provided strategic oversight.

4.58 Clinical governance meetings took place on a monthly basis, but attendance by clinical leaders was inconsistent, which meant that the meeting lacked the necessary critical oversight. Serious incidents were promptly reported, but an underreporting of low-level incidents meant that it was not possible to identify any trends, risks or gaps in the service. Staff were unable to advise us of an incident, where lessons had been learned or where a change in practice or service delivery had been implemented. (See key concern and recommendation 1.48 and paragraph 4.80.)

4.59 We observed conscientious and considerate staff in all teams, interacting with their patients in a respectful and caring manner.

4.60 Compliance with mandatory training was good. Managerial and clinical supervision was embedded in practice. Just under 50% of the primary care team had started in post within the previous six months, all of whom had received supervision and participated in an induction programme.

4.61 Both Oxleas NHS Foundation Trust and Forward Trust collected patient feedback and ran patient forums to inform service improvements.

4.62 Our survey indicated that patients were more dissatisfied with the access and quality of health care services than at our previous inspection – only 23% said health care services were very or quite good. This was consistent with feedback from two patient surveys that the health care provider had undertaken during the pandemic. The health care representative forum had been implemented during the pandemic, which saw health care wing representatives meet regularly with the head of health care and prison lead staff member to discuss any issues with the providers. The forum allowed for open communication with the providers and gave representatives the opportunity to share feedback with prisoners on the wings.

4.63 Social distancing restrictions meant only two out of three clinical rooms in the health care department were in use. This had an impact on the range of clinics on offer.

4.64 An annual infection control audit completed in February 2021 had identified clinical areas that did not comply with environmental standards and needed to be addressed.

4.65 SystmOne, the electronic clinical information system, was used by health staff and for substance misuse clinical interventions and prescribing. Clinical and psychosocial service managers worked closely. However, three clinical records were being used for substance misuse, which was not good practice and carried risks.

4.66 Emergency resuscitation equipment was in good order and effectively monitored. Staff had completed mandatory adult basic or intermediate life support training that was appropriate for their role. During the pandemic, two senior clinical staff had been recruited. They provided an emergency response and triaged patients effectively.

4.67 Patients had access to a health care complaints system. However, it was not advertised well enough, and all complaints had come through the prison system, which was not confidential. Sampled responses were reasonably respectful and addressed the issues highlighted, but some were poorly written. Oversight of the process was inadequate. Action was taken during the inspection to address these issues and we were confident that changes had been made to improve the process.

Recommendation

4.68 **Patients should have a single set of notes to ensure patient safety and continuity of care.**

Promoting health and well-being

4.69 Although there was no overarching local health promotion strategy, health promotion material was visible across the prison. It was updated in line with the national health promotion calendar.

4.70 All the posters were in English, but we were advised that health care staff had access to telephone interpretation for appointments and some

leaflets were available in other languages in the health care department.

4.71 A range of prevention programmes, including bowel cancer, aortic aneurism and retinal screenings, had not restarted.

4.72 COVID-19 vaccination clinics had been held, and there was an ongoing campaign to promote vaccinations as we were advised that 35% of the population had declined to be vaccinated. Patients who were eligible for the flu vaccination had been identified and the campaign had started during the inspection. Hepatitis B vaccinations had been suspended since the start of the pandemic.

Primary care

4.73 A registered nurse carried out an initial health screening for all new arrivals on the day of reception. A prompt referral to specialist follow-up services was made, alongside testing and offering information on COVID-19. Secondary health assessments took place within seven days of a prisoner's arrival.

4.74 A committed and enthusiastic staff team delivered primary health care, providing a good quality service. However, there was inadequate space in the primary care department to offer the full range of services effectively, and there were long waiting times for some clinical monitoring procedures, such as electrocardiograms (ECGs) (see paragraph 4.91).

4.75 Primary care services included podiatry and optometry, but no pain clinic had been made available. COVID-19 restrictions meant that patients' long-term conditions were managed by GPs from a local practice, who provided planned sessions throughout the week.

4.76 There were plans to reintroduce nurse-led, long-term conditions clinics and nurses had been identified to take the lead in this area. All patients we reviewed had a care plan; however, not all patients were involved in their care planning, and some reviews were overdue.

4.77 No formal multidisciplinary meetings were held to discuss complex cases so treatment options could be shared. While nurses worked closely with GPs to share information about risks, not all systems supported the effective sharing of information.

4.78 Primary care nurses were available from 7.45am to 7.30pm, Monday to Thursday, with slightly reduced hours on Friday and at the weekend. Prisoners' applications requesting a health appointment were triaged by an appropriate clinician, which made sure patients' needs were met. The nursing team provided daily clinics, including a triage clinic, supported by the GP.

4.79 The primary care appointments system was managed in line with the prison's pandemic restrictions. This led to some delays in prisoners' access to services. Waiting times for routine appointments to see the GP were too long at five weeks, longer than our expectation of within

two weeks. Urgent appointments were made for the same or following day. Waiting times to see the optician were reasonable.

4.80 The number of prison escorts had been reduced to four days a week so that dental clinics could operate. This meant there were up to 16 fewer hospital appointments per month. Escorts could also be cancelled due to prison staff shortages. There was an effective system for managing external hospital appointments, including clinically triaging patients when appointments were cancelled or required rescheduling. The decision, however, was not recorded in patient records and the patient was not made aware of a delay. This was not in line with duty of candour requirements (a legal duty to provide patients with information.) On occasion, an incident was not reported when health care staff failed to be informed about a patient not having been escorted to an external appointment. (See key concern and recommendation 1.48 and paragraph 4.58.)

4.81 Prior to their release, patients received advice and support on how to register with a GP, and referrals were made to community services as required.

Recommendation

4.82 **Patients should have timely access to secondary care treatment and duty of candour should be applied when a patient's appointment is cancelled.**

Social care

4.83 A memorandum of understanding (MOU) for social care was in place between HM Prison and Probation Service, the health care provider and Medway County Council. However, adult social care group steering group meetings had not taken place as specified in the MOU. We found communication between the prison, the health care provider and the local authority to be poor, leading to delays in the assessment of some patients.

4.84 During the inspection, two patients who required equipment or adaptations had experienced delays, one for over three months. The named provider of some equipment detailed in the MOU was not accurate and contributed to the delay. Care plans were in place and the health care provider completed PEEPs for individuals with identified needs. There was no peer support, but prisoners with restricted mobility could obtain assistance in an emergency.

Recommendation

4.85 **Patients should be assessed promptly and provided with suitable equipment to meet their needs.**

Mental health care

4.86 Mental health services were delivered by Oxleas NHS Foundation Trust. A stepped care model (mental health services that address low

level anxiety and depression through to severe and enduring needs) was delivered by the mental health in-reach team at the trust and the Bradley Therapy Service (BTS).

4.87 The prevalence of mental health was similar to our previous inspection – 57% of those we surveyed told us they had a mental health problem but only 16% said it was easy to see a mental health worker.

4.88 The integrated team received approximately 80 joint referrals each month. A comprehensive health record review was carried out for each referral and missing information was sought from GP and community teams. All referrals were logged and allocated at the weekly referrals and allocations meeting. A complex case meeting was also held every week, involving a multidisciplinary health care team, which made sure care was consistent.

4.89 The care programme approach was used effectively to support patients with severe and enduring mental illness and all clinical records we reviewed were comprehensive and of good quality. Caseloads were small, but waiting times for the BST were increasing because of staff shortages and regime restrictions. All groups had now been converted to one-to-one session because of restrictions on prisoners' movements, which was more time consuming and added to the waiting time. The mental health team was fully staffed, apart from two psychology assistant vacancies at the BTS. Staff were being recruited for these posts.

4.90 There was no learning disability expertise, but there were clear pathways for patients with attention deficit hyperactivity disorder (ADHD) and post-traumatic stress disorder. A busy psychiatrist provided a weekly clinic, but they had to see patients in wing offices, which was not therapeutic and limited confidentiality. It also meant they lacked access to clinical records (see paragraph 4.101). There was no evidence of officers having received any mental health training since the beginning of the pandemic.

4.91 Physical health checks were undertaken by mental health team nurses, who were now trained in phlebotomy. Health checks for those starting on ADHD medications were delayed, with one patient waiting the longest time of 10 months; a second patient waited four months for an ECG. This was not acceptable. (See key concern and recommendation 1.48.) Mental health nurses attended ACCT case reviews and the segregation unit every week.

4.92 Patients who required admission under the Mental Health Act were managed well but rarely transferred within national guidelines. If risks were high, arrangements were made to transfer them to HMP Elmley's inpatient unit.

4.93 Patients who were being released under the care of the mental health team were managed on an individual basis. Joint discharge plans with all interested parties were in place for more complex cases, but this was the exception.

Recommendations

4.94 **Mental health treatment or therapy should start promptly and delays in treatment should be reported as a clinical incident.**

4.95 **The transfer of patients to hospital under the Mental Health Act should take place within Department of Health guidance timescales.**

Substance misuse treatment

4.96 There was an out-of-date drug strategy, which did not reflect current activities. All new arrivals were screened to determine their drug and alcohol needs, and referrals were made as appropriate to substance misuse services. All notes of newly arrived prisoners were screened the next day by a nurse to catch any that had been overlooked. Assessments were prompt and took place face to face, and any prescribing was undertaken by a specialist GP and in line with national guidance.

4.97 In our survey, 28% of prisoners said they had a drug problem when they arrived, 68% of whom said they had received help.

4.98 Fifty-six patients were on opiate substitution therapy (OST), 41 of whom were on maintenance doses and 15 of whom were detoxing. There were approximately 240 prisoners on the psychosocial caseload.

4.99 Joint working was evident from clinical records. We saw risk management mitigation and planned interventions. Harm reduction information was offered on arrival, during interventions and on release. Clinical and managerial supervision was available, and staff told us they felt supported. There were three clinical nurse positions – one had been filled by one of two long-term agency nurses, another was held by someone on long-term sick leave, while the third position was vacant. There were 1.5 vacancies in the psychosocial team awaiting recruitment.

4.100 The drug recovery unit on A wing had continued to deliver activities during the prison restrictions for its 78 residents. Alcoholics Anonymous and Cocaine Anonymous meetings had been suspended for those on the wings but had continued on A wing. Those held on the other wings who required OST and psychosocial interventions received one-to-one care, which was less intensive. There were no peer support workers for substance misuse services on any wing.

4.101 For those not on A wing, safe and therapeutic space was not always available for face-to-face substance misuse interventions. This had the same impact as appointments undertaken by the mental health team. (See paragraph 4.90.)

4.102 Discharge plans were started in good time and included harm minimisation training, referrals and joint working with community drug services.

Medicines optimisation and pharmacy services

4.103 The pharmacy team was based in an on-site dispensary. Some medicines use reviews, which had been suspended due to COVID-19 had been reintroduced.

4.104 Patients who could not have medication in their possession attended an administration hatch to receive their medicines. Medicines were packed into plastic pouches for each administration, each containing multiple medicines. Although they were labelled appropriately, some patients had a number of pouches for administration at the same time, which presented a risk and needed to be reviewed. We observed delays in the supply of some medication, but critical medicines were maintained.

4.105 Seventy per cent of patients had their medicines in possession, 20% of whom received seven days of medication, which was high. A significant number (4%) received their in-possession medication every day, which is not recommended. Most risk assessments undertaken on reception were not routinely checked to make sure they were up to date. Patients were not encouraged to have medicines in possession, which did not support independent care.

4.106 Nurses and pharmacy technicians administered medication three times a day, with no provision for night-time medicines. Medication-related incidents were not reported robustly. (See key concern and recommendation 1.48.) We observed queues being inconsistently supervised, which meant patient confidentiality was not maintained and the likelihood of diversion was increased.

4.107 Suitable medicines were available to treat minor ailments. There was an out-of-hours' policy and a supply of common emergency medicines. Audits of the use of these medicines were poor. There were prison-specific quarterly medicines management and quality assurance meetings to discuss any issues.

Dental services and oral health

4.108 The dentist had returned to provide a two-day a week service. They delivered a range of dental treatments, including dental therapy to promote oral health, although aerosol generating procedures had not yet resumed, which was causing a delay in treatment for some patients.

4.109 In our survey, 5% of respondents said it was easy to see the dentist; however, patients were seen within five weeks. The dentist was responsive to patients who required urgent care and filled gaps arising from patients who did not attend appointments by offering them to patients from a nearby wing.

4.110 While the main dental suite was clean and tidy, the adjoining room used for sterilising equipment did not meet infection prevention and control standards. The floor had been peeled back from the skirting, the

top of the steriliser was dusty, and an extension lead with a dirty cable was resting on the worktop between the sink and sterilising unit. Additionally, an adjacent office area was cluttered with boxes on the floor, which presented a risk.

4.111 Internal governance arrangements were not quality assured and dental governance processes, including regular reviews of clinical records and the infection prevention and control checks, were incomplete. (See key concern and recommendation 1.48.)

Section 5 Purposeful activity

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

Time out of cell

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

5.1 The prison had moved to HMPPS regime stage two shortly before the inspection. A split regime was in operation whereby half of the prison was locked up, while the other half spent a short period of time out of their cells. Leaders attributed these measures to both COVID-19 cohorting arrangements and a shortage of staff needed to support a full regime. As a result, most prisoners usually spent more than 22 hours a day locked in their cells. Leaders claimed that adherence to these stringent measures provided consistency and reduced the likelihood that the regime would be curtailed at short notice. However, in our survey, far fewer respondents than in 2017 said unlocking times were adhered to (59% compared with 76%). (See key concern and recommendation 1.49.)

5.2 In our survey, prisoners were far more negative about time out of cell than at the previous inspection – 80% said they spent less than two hours unlocked on a week day compared with 13% in 2017. Only 49% said they had enough time to complete their domestic tasks.

5.3 During our roll checks, we found over 60% of prisoners locked up during the core day. (See key concern and recommendation 1.49.)

5.4 Despite the reduced time out of cell overall, the regime did provide prisoners with some evening association which we have observed rarely during the pandemic. In our survey, prisoners were more positive than at the previous inspection about being able to associate with their peers (68% compared with 51%) and exercise in the open air (68% compared with 52%).

5.5 Only one in four prisoners participated in purposeful activity, which was very low for a category C prison. The majority of activity places were for wing workers, primarily cleaners, and those we observed had little work to do. Many prisoners told us that being locked up for so long every day with little to do was having a detrimental effect on their mental well-being. (See key concern and recommendation 1.49.)

5.6 Prior to COVID-19, the prison offered over 500 activity places. This had been reduced by half during the restrictions. The prison planned to

increase the activity spaces to 336 in the week following the inspection, although over 100 of them consisted of wing work.

5.7 Planning for a return to a full regime was at a very early stage. The only decision that had been made was that there would be no mass movement of prisoners – instead prisoners would be escorted to and from activities. Due to this constraint, leaders estimated that even in the absence of COVID-19 restrictions there would not be sufficient staff in post to offer a full regime until at least spring 2022. (See key concern and recommendation 1.49.)

5.8 Gym staff promptly introduced outside sessions when the pandemic began, and, when national restrictions were eased, the sports hall was reopened. At the time of the inspection, indoor gym sessions had started again, but most prisoners could only attend once or twice a week. Some prisoners could not attend any sessions, for example, those in the reverse cohort units (see paragraph 3.10).

5.9 The prison had gym facilities in both the original and new buildings. However, only half the showers in the original building were working, which meant prisoners could not have a shower after a gym session.

5.10 The prison had reintroduced some good accredited programmes, such as Football Association coaching level 1, and the Duke of Edinburgh Scheme.

5.11 The library closed at the start of the pandemic and remained closed during our inspection. We were informed that the facility was opening in the coming weeks but only on a limited basis.

5.12 Prisoners still had to place orders for books to be delivered. A good range of library books was available through the delivery service, but it was not an adequate long-term alternative to a proper library provision. Legal texts were out of date and required replacement.

5.13 The promotion of literacy was weak and the number of prisoners using the library service was approximately one third of pre-pandemic levels. Reading groups, such as those run by the Shannon Trust, and the Storybook Dads scheme, which helps prisoners record a story for their children to listen to at home, were still not available.

Education, skills and work activities

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.

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

5.15 During the pandemic-related national restrictions, leaders followed government guidance and restricted all activities to those that were critical to the functioning of the prison, such as waste management. Education, skills and work (ESW) activities were suspended, but prisoners began accessing a range of in-cell education packs.

5.16 Following the second period of national restrictions, education staff were able to visit prisoners on the wings at lunchtime to support them through the cell door. Although this did not allow for face-to-face support, it did offer prisoners some limited contact. Prisoners' feedback and answers to their queries had started to take place in person.

5.17 From July 2021, the shortage of operational prison staff had a detrimental impact on prisoners' ability to access ESW activities. As a result, the progress leaders had made towards making sure a full curriculum was being taught and that prisoners' support needs were being met, had been too slow. During our visit, too few prisoners were taking part in any form of purposeful activity, whether remotely or face to face. Leaders acknowledged that expanding the ESW curriculum had not been possible as they had prioritised safety and offering all prisoners time out of cell.

5.18 Since the restricted regime began, education and training staff had only been able to interact with prisoners individually on the wings during the little time that prisoners had been allowed out of their cell. The environment was challenging and noisy, as prisoners also attempted to carry out many other necessary activities, such as domestic tasks. As a result, they had very little time to contact staff, putting them at a disadvantage.

5.19 Leaders had put plans in place to expand the activities being delivered as they moved to stage 2 of the national framework for prison regimes and services. However, they recognised that staffing shortages had not been resolved.

5.20 The number of prisoners who had used in-cell education packs was extremely low. Most packs were of a suitable standard and had been appropriately marked. Teachers provided constructive and thoughtful feedback to support prisoners to make progress in their learning. Since July 2021, education staff had offered accredited in-cell learning packs in English, mathematics and information and communications technology (ICT). A small number of prisoners had achieved certificates in mathematics at entry level, level 1 and level 2 and in ICT.

5.21 Staff had made suitable plans to reintroduce classroom and workshop teaching. They included a review and reassessment of the gaps in prisoners' learning, adjusting their courses accordingly.

5.22 Leaders had continued to interact with external businesses to develop training that might lead to employment opportunities for prisoners following release, for example in the roofing industry or in events stewarding.

5.23 Managers did not sufficiently prioritise digital learning, and prisoners did not develop the vital digital skills they needed to support their resettlement. Access to digital equipment and platforms was minimal and the virtual campus (prisoner access to community education, training and employment opportunities via the internet) was not connected. Only one prisoner undertaking distance learning had access to technology to support their studies. Managers in education made sure that they received the support from their external distance learning tutors.

5.24 Managers had not planned well prisoners' access to any form of one-to-one support from careers advice and guidance workers. Workers attempted to interact with prisoners during the short time they spent out of their cells. This meant prisoners did not receive the support they needed to make informed career choices. The careers guidance team held up-to-date local job information and could match prisoners effectively to job opportunities as they reached release. However, this service had been negatively affected by the restrictions.

5.25 Managers acknowledged that the induction into education was not effective. On arrival, prisoners spent 10 days in isolation and undertook a range of induction and initial assessment activities, unsupported in their cell. This included 'self-declaring' whether they had any additional learning needs. Managers recognised how these activities needed to take place face to face to meet prisoners' needs. Once prisoners had been transferred to the wings, teachers struggled to find time in their allocated time out of cell to give prisoners individual guidance and learning support. However, they were sensitive and aware of those who may not have declared their needs but displayed difficulties with learning.

5.26 In the very few activities visited, prisoners engaged well and were attentive and pleased to be with their peers, teaching staff and instructors. There were good levels of co-operation and good relationships between prisoners and staff.

Recommendations

5.27 **Leaders and managers must urgently prioritise increasing the number of face-to-face places in education, skills and work activities so that a significantly larger number of prisoners are able to access and attend activities.**

5.28 **The induction to education and training and initial advice and guidance support should be provided to prisoners' face to face to enable them to plan their learning and potential next steps more comprehensively.**

5.29 **Leaders must increase prisoners' access to and the provision of technology, such as the virtual campus to enable prisoners to develop vital digital skills to support their resettlement.**

Section 6 Rehabilitation and release planning

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

Children and families and contact with the outside world

Expected outcomes: The prison supports prisoners' contact with their families and friends. Programmes aimed at developing parenting and relationship skills are facilitated by the prison. Prisoners not receiving visits are supported in other ways to establish or maintain family support.

6.1 The prison had a strategy to promote contact between prisoners and their children and families, but it had been drafted in 2019 and had not been revised to reflect restrictions during the pandemic. In our survey, only 21% of prisoners said that staff had encouraged them to keep in touch with their family and friends.

6.2 Social visits had resumed in May 2021, by which time most prisoners would not have seen their families for over six months. Social visits were available five days a week and supplemented by secure video calls which were available six days a week. Managers continued to monitor take-up and respond appropriately to maximise capacity.

6.3 Visitors were initially received in a welcoming visitors' centre by enthusiastic staff from the Spurgeons charity, who focused on providing prisoners and their visitors with good support. Refreshments were now available in both the visitors' centre and the visits room.

6.4 Visiting sessions were too short at 45 minutes and reflected the minimum that the prison was permitted to deliver under stage 3 of the national framework for prison regimes and services. Prisoners were also required to wear sashes for identification purposes, which seemed unnecessary in a category C prison.

6.5 Adult visitors who provided a negative COVID-19 test immediately prior to their visit were permitted physical contact with prisoners, such as a hug at the start and end of the visit. There were no restrictions on the level of contact children under 11 were permitted.

6.6 All visitors we spoke to said they had been treated with respect and visiting sessions we observed started on time. The visits hall was generally in good condition and staff provided activities and distractions for children to complete at the table with their families. Neither prisoners nor their adult visitors could use the toilet during the visit. Staff were unsure of the process for providing children with toilet access.

6.7 Virtual visits took place in legal visits rooms. Unlike at some other prisons, the establishment had not made efforts to make virtual visits seem less institutionalised by enhancing the surroundings, particularly when children were seeing their father in prison. Spurgeons did, however, provide duplicate books for prisoners and their children so fathers could read to their child online.

6.8 Family days remained suspended since the start of the pandemic. Parenting and family relationship courses and support were available through the Prison Advice and Care Trust and Spurgeons. Spurgeons had been particularly innovative in finding ways to support prisoners and their families, for example, linking with a local charity so that fathers could provide gifts to their new-born children and providing a hygiene bank in the visitors' centre where families with financial difficulties could collect basic toiletries and baby products free of charge. (See paragraph 1.52.)

6.9 Prisoners appreciated access to in-cell phones, which had offset to a small extent the suspension of social visits. In our survey, 98% of prisoners said they could use the phone every day if they had credit. However, staff and service providers were unable to phone prisoners in their cells, a facility that was available and greatly valued in other prisons.

6.10 Despite all mail being scanned (see paragraph 3.40) we found no delays in its distribution nor in correspondence received through the Email A Prisoner scheme, which was well used. Prisoners were, however, not permitted to have birthday cards unless they were sent directly through approved suppliers.

Recommendation

6.11 **The visits provision should be extended to provide longer sessions, including at weekends.**

Reducing risk, rehabilitation and progression

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

6.12 An up-to-date reducing reoffending strategy was in place but was largely descriptive and did not outline the requirement for coordinated working with other departments. Work to reduce reoffending was undermined by the lack of a comprehensive needs analysis and action plan. There had only been two meetings to focus on delivering the strategy since the start of the pandemic.

6.13 The offender management unit (OMU) had a good understanding of the risk profile of the population – about 40% of prisoners presented a high or very high risk of harm to others, with 60% serving a long or

indeterminate sentence. The offender management in custody model (see Appendix II Glossary of terms) had been implemented and staff in the department understood how it operated.

6.14 The OMU was adequately staffed. Caseloads for prison offender managers (POMs) were reasonable at approximately 60 for probation POMs and 50 for prison officer POMs. All POMs received regular formal supervision. To inform these sessions, all POMs completed a 'delivery report' in advance, which was a simple but effective way to record the work they had done, provide assurance to managers, and stimulate useful discussion during supervision. (See paragraph 1.53.)

6.15 Many POMs had been given the responsibility for developing their expertise in specific thematic areas, such as care leavers, mental health, and foreign national prisoners. POMS were not exclusively allocated such cases but were a point of reference within the OMU. (See paragraph 1.54.)

6.16 In our survey, 74% of prisoners said they had a custody plan, but only 32% of them said that staff were helping them achieve their targets. POMs had maintained face-to-face contact with prisoners throughout COVID-19 restrictions to a greater extent than we usually see. In the sample of 20 cases we examined, contact between POMs and prisoners took place frequently enough to promote progress in most cases. There was, however, very little evidence of key workers supporting offender management work (see paragraph 4.4) as key work focused on prisoners' general welfare.

6.17 Managers reported that HM Prison and Probation Service allocation protocols, introduced in September 2020, had resulted in prisoners arriving with longer tariffs, at an earlier point in their sentence and with no offender assessment system (OASys) report outlining their risks and needs. Despite these issues, the OASys backlog was small. During the inspection, 539 (83%) of eligible prisoners had an OASys report that had been completed in the previous 12 months, and only 28 prisoners had no initial assessment. Most of the prisoners whose cases we examined in depth had sentence plans of at least a reasonably good standard, and some were very good. Progress against sentence plan targets was sufficient in just over half of the cases we reviewed in detail.

6.18 There had been approximately 200 home detention curfew (HDC) releases in the previous 12 months. Although processes were generally sound, only 54% of cases had been approved, which was low. A combination of unsuitable accommodation and prisoners arriving at Rochester only shortly before or after they qualified for HDC, meant about one third of releases had taken place beyond their eligibility date. This was a poor outcome for prisoners.

6.19 Release on temporary licence remained suspended, which particularly affected the large number of category D prisoners who remained at Rochester with no way of demonstrating their reduced risks.

6.20 About three quarters of the population were subject to parole release and POMs carried out the assessments needed. Regional psychology staff carried out psychological assessments for those referred to them by POMs, which were required for parole board hearings. During the previous 12 months, 69 parole board hearings had taken place, either through paper hearings (where the board reviews documentary evidence only), video-link or telephone conferencing. Some face-to-face hearings had now been scheduled. The parole board had called for prisoners to be released on 46 occasions, but a fifth of cases had been deferred or adjourned.

6.21 During the inspection, 66 prisoners had experienced being in care. They received very good support, for example through consultation forums involving a care leaver specialist from the local authority (see paragraph 1.55). Discussions were held on the type of support care leavers were entitled to once they had turned 18, and plans were in place for other outside agencies that support care leavers in custody to prepare them for their release. The prison also maintained data on care leavers, such as on their involvement in incidents of violence or self-harm.

Recommendation

6.22 **A comprehensive needs analysis should be used to inform a prison-wide reducing reoffending strategy, accompanied by an action plan to address prisoners' needs.**

Public protection

6.23 Two 1.5 full-time equivalent senior probation officers (SPOs) were now in post. They provided assurance and expertise on risk management matters. Virtually all the cases we reviewed in detail had up-to-date risk management plans and were reasonably good.

6.24 The interdepartmental risk management team meeting met every month. The team had recently resumed face-to-face meetings, which were reasonably well attended. They had an appropriate agenda and terms of reference, and a good range of prisoners were discussed. Good use was being made of the public protection assurance toolkit, a framework to improve oversight and case management of prisoners. The terms of reference also prompted discussions about other prisoners whose behaviour was causing concern, for example those in long-term segregation. To keep the number of prisoners being discussed manageable, all were reviewed at eight and two months prior to release and cases were examined in other meetings only if there was a specific issue that required broader discussion.

6.25 Some minutes did not indicate if previously set action had been completed, which was unhelpful, but overall, we saw improvements in subsequent meeting minutes, as processes became more embedded.

6.26 All multi-agency public protection arrangement (MAPPA) levels in our case sample were confirmed before the prisoner's release, and there

was good evidence of POMs liaising with community offender managers to confirm arrangements. We also found good evidence of effective SPO intervention in several cases, where community counterparts had failed to cooperate with POMs.

6.27 We looked at 10 MAPPA F information sharing reports, which had been completed for community meetings, and found most to be adequate. All had been counter-signed, but half were not dated. Where dates were provided, we found all reports were timely with never fewer than two days between completion and the community MAPPA meeting. Staff participated in community meetings via video or telephone conferencing.

6.28 During the inspection, 37 prisoners were subject to telephone monitoring. Monitoring arrangements were weak. For example, decisions about whether to monitor or stop monitoring a prisoner were not reached as part of a multidisciplinary review, which introduced some risks. We found at least one case where the justification for continued monitoring was not sufficient in our opinion.

6.29 We found a significant backlog of calls waiting to be monitored. There were cases of prisoners with 50-100 phone calls that had not been dealt with. It was not unusual, we were told, for a prisoner not to have a single call monitored until a month after they had been placed on the process.

Recommendation

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

Categorisation and transfers

6.31 Categorisation procedures were functioning well, and few cases were overdue. Prisoners did not attend reviews but were able to submit written contributions and were informed of the outcome by POMs.

6.32 Records we reviewed were sufficiently good and indicated that decisions were justifiable. Where prisoners had been unsuccessful in reaching a lower security category, staff attempted to provide an explanation and encouragement to make sure they were successful in future.

6.33 During the previous 12 months, 613 prisoners had been allocated category C status and seven category B. Despite the lack of progression options, such as a reduced number of opportunities to complete offending behaviour programmes (see paragraphs 6.37 and 6.38), leaders had taken a pragmatic and broad view in assessing prisoners' suitability for category D status. This meant 297 prisoners had been assessed for open conditions. However, 91 prisoners remained at Rochester awaiting a progressive move. Some had been waiting many months, which caused prisoners to become frustrated,

particularly as they were subject to the same restrictions and regime as category C prisoners.

6.34 During the inspection, 24 prisoners were serving life or indeterminate sentences. No additional work was being undertaken with this group and lifer days and forums had not been held since the start of the pandemic.

Recommendation

6.35 **Progressive transfers should be facilitated promptly when prisoners are re-categorised to category D status.**

Interventions

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

6.36 A needs analysis had not been conducted since before the pandemic. Two medium intensity courses, Resolve (a cognitive-behavioural intervention for violent offenders) and the Thinking Skills Programme, were the main accredited course available. Although there was some evidence that a course to address domestic violence was required to meet the needs of some of the prisoner population, there were no plans to introduce one.

6.37 Courses had been delivered in a group setting in the previous 12 months, but for a much-reduced number of prisoners. Low staffing levels meant the prison could not deliver enough courses to meet the needs of the population.

6.38 Waiting lists for available courses continued to increase. Local managers estimated that half the population were likely to have had needs that had not been met and nearly a quarter (approximately 160 prisoners) were on waiting lists. The prison's lack of courses meant some prisoners had been and would continue to be released without having had an assessment or having completed key offending behaviour work. As a result, community offender managers had an incomplete understanding of the prisoners' needs and risks in the community.

6.39 Some POMs had undertaken one-to-one offending behaviour work with prisoners who were unable to take part in accredited training, which was good. About 30 prisoners had benefited or were benefiting from these interventions, which, while not a great number, was better than we have seen recently.

Release planning

Expected outcomes: The specific reintegration needs of individual prisoners are met through an individual multi-agency plan to maximise the likelihood of successful reintegration into the community.

6.40 There had been about 60 releases per month over the previous 12 months.

6.41 Some support was available for all prisoners with finance, benefit and debt issues, and medium and low risk of harm offenders received help with accommodation. In high-risk cases, we saw prisoners' accommodation needs being addressed by the community offender manager, who allocated a place in approved premises. Data supplied by the prison indicated 86% of those released had spent their first night in sustainable accommodation in the previous 12 months.

6.42 Key partners had all now returned to the prison and were seeing prisoners face to face. However, their work required better coordination and promotion as staff and prisoners were often unaware of the different services available, even when they were based in the prison.

6.43 OASys reports in the cases we reviewed in detail did not contain basic custody screening (BCS) resettlement plans, although this did not necessarily mean that they did not receive support leading up to their release. Of the 10 cases we reviewed of prisoners who were within three months of being released, only one had a formal BCS2 resettlement plan. However, prisoners nearing release did not appear frustrated that no-one was working to support them, and P-Nomis entries and conversations with prisoners confirmed that a resettlement worker had contacted them to identify their resettlement needs.

6.44 We found good evidence of POMs liaising with external community offender managers to confirm resettlement information as part of their handover process.

Section 7 Recommendations in this report

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

Key concerns and recommendations

7.1 Key concern (1.42): There were weaknesses in the support provided to new arrivals. First night interviews did not assess prisoners' immediate risks and vulnerabilities thoroughly enough to ensure that staff could provide appropriate support. The regime on the reverse cohorting units was poor, which limited opportunities for staff to identify prisoners at risk of self-harm. There was no formal induction programme, and prisoners did not have access to Listeners or other peer workers to help them understand what to expect from their early days in custody, or how to access sources of support.

Recommendation: Safeguards should be in place to ensure that all prisoners arriving at Rochester are kept safe, including a thorough risk assessment of their needs, and have access to relevant information and proactive support from staff and peer workers during their early days in custody. (To the governor)

7.2 Key concern (1.43): Rates of attrition and staff shortfalls impacted on the prison's ability to deliver a full regime. Drugs were identified as a key threat but there were insufficient staff to carry out mandatory drug testing and target searching. External hospital appointments were restricted, and some were cancelled. The prison could not deliver enough courses to meet the needs of the population. Staffing shortfalls were likely to delay progress to a full regime until at least spring 2022.

Recommendation: There should be clear measures to recruit, train, and retain operational staff to keep prisoners safe and healthy and deliver a full rehabilitative regime. (To HMPPS and the governor)

7.3 Key concern (1.44): There were weaknesses in the prisons' approach to maintaining safety. The policy was out of date, data was not analysed to determine the risks of rising violence and self-harm as restrictions eased and there were no plans to counteract these risks. There were few proactive interventions to manage the perpetrators of violence and little support for victims. There were no arrangements for logging or monitoring referrals made to the safer custody team and we found one case of bullying that was not acted on for this reason.

Recommendation: The strategy to improve safety outcomes should be informed by good data analysis and include an effective action plan to reduce violence and self-harm. (To the governor)

7.4 Key concern (1.45): In our survey significantly fewer prisoners than last time said staff treated them with respect (66% compared with 78%). Limited time out of cell restricted the time available for positive relationships to develop. Staff had little time to help prisoners with day-to-day issues. Key work duties were cancelled which compounded this problem. There was no evidence of key workers supporting prisoners on ACCT case management or challenge, support and intervention plans.

Recommendation: Staffing levels and prisoners' time out of cell should be increased to facilitate the development of productive and positive relationships. (To the governor)

7.5 Key concern (1.46): The cells in the older accommodation blocks were dingy and dilapidated and in need of continual repair, leaking plumbing was commonplace, and in some cells the electricity wiring appeared to be in a dangerous state. There was an ongoing problem with a rodent infestation that affected most prisoners. None of the single cells had toilet screens, which was undignified. Most windows across the prison needed to be repaired or replaced as the ventilation hatches could not be opened, which meant it was difficult to regulate the temperature in the cells.

Recommendation: Cells in the older part of the prison should be taken out of commission and refurbished or replaced to ensure that all prisoners live in cells that are safe, decent and comfortable. (To the governor and HMPPS)

7.6 Key concern (1.47): Prisoners told us about problems accessing their stored property, and, in 2021, almost a third of all complaints related to the issue. There were delays in processing property and answering prisoners' queries, leading to frustration. Records were not always complete, which meant it was not possible to find items. Some prisoners waited months to receive items sent in by post.

Recommendation: Prisoners should have ready access to their stored property. Requests for access should be dealt with within agreed and published time scales following consultation with prisoners. (To the governor and HMPPS)

7.7 Key concern (1.48): Clinical governance systems and processes were underdeveloped across primary care and dental services. This included the management of complaints, infection prevention and control oversight and learning lessons from incidents. We were not confident that factors affecting patient safety were identified or addressed in a timely manner.

Recommendation: Robust governance procedures, including consistent incident reporting and investigation, should be implemented to ensure that concerns affecting patient safety are promptly addressed. (To the governor)

7.8 Key concern (1.49): Most prisoners were locked in their cells for over 22 hours a day, with little to keep them occupied, which was having a detrimental effect on their well-being. The prison had been slow to expand the regime, partly because of staff shortages. The prison did not have a clear plan for a complete regime recovery.

Recommendation: All prisoners should have adequate time out of cell to participate in a regime that includes purposeful activity, time to complete domestic chores and the opportunity to socialise with their peers. (To the governor)

Recommendations

7.9 Recommendation (3.17): Rewards and sanctions should motivate prisoners to participate in the regime and support their progression. (To the governor)

7.10 Recommendation (3.21): Action to address issues identified at the segregation monitoring and review group should be specific, measurable and time bound to make sure that the process deals with the most serious offences effectively. (To the governor)

7.11 Recommendation (3.26): Quality assurance procedures should be sufficiently robust and thorough to make sure all incidents where force is used are justified, proportionate and only used as a last resort. (To the governor)

7.12 Recommendation (3.32): As a minimum, prisoners should be able to have a shower, make a phone call and spend time in the fresh air every day. (To the governor)

7.13 Recommendation (3.33): Health care staff should attend all segregation reviews. (To the governor)

7.14 Recommendation (3.34): Target setting in segregation paperwork and reintegration plans should be meaningful and tailored to the individual. (To the governor)

7.15 Recommendation (3.35): Prisoners should only be segregated pending adjudication if they pose a significant risk. (To the governor)

7.16 Recommendation (3.42): Security meetings should lead to clear action plans that are specific, measurable and time bound to reduce the security risks facing the prison. (To the governor)

7.17 Recommendation (4.30): Robust tracking and management intervention should be introduced to ensure the timeliness of responses to applications. (To the governor)

7.18 Recommendation (4.31): The prison should review the complaint system to make sure that responses are appropriate, allegations of discrimination are properly recorded, and data are analysed to identify and address common themes. (To the governor.)

7.19 Recommendation (4.68): Patients should have a single set of notes to ensure patient safety and continuity of care. (To the governor)

7.20 Recommendation (4.82): Patients should have timely access to secondary care treatment and duty of candour should be applied when a patient's appointment is cancelled. (To the governor)

7.21 Recommendation (4.85): Patients should be assessed promptly and provided with suitable equipment to meet their needs. (To the governor)

7.22 Recommendation (4.94): Mental health treatment or therapy should start promptly and delays in treatment should be reported as a clinical incident. (To the governor)

7.23 Recommendation (4.95): The transfer of patients to hospital under the Mental Health Act should take place within Department of Health guidance timescales. (To the governor)

7.24 Recommendation (5.27): Leaders and managers must urgently prioritise increasing the number of face-to-face places in education, skills and work activities so that a significantly larger number of prisoners are able to access and attend activities. (To the governor)

7.25 Recommendation (5.28): The induction to education and training and initial advice and guidance support should be provided to prisoners' face to face to enable them to plan their learning and potential next steps more comprehensively. (To the governor)

7.26 Recommendation (5.29): Leaders must increase prisoners' access to and the provision of technology, such as the virtual campus to enable prisoners to develop vital digital skills to support their resettlement. (To the governor)

7.27 Recommendation (6.11): The visits provision should be extended to provide longer sessions, including at weekends. (To the governor)

7.28 Recommendation (6.22): A comprehensive needs analysis should be used to inform a prison-wide reducing reoffending strategy, accompanied by an action plan to address prisoners' needs. (To the governor)

7.29 Recommendation (6.30): Public protection monitoring should be timely and effective to reduce the risks of harassment and further criminal activity. (To the governor)

7.30 Recommendation (6.35: Progressive transfers should be facilitated promptly when prisoners are re-categorised to category D status. (To the governor and HMPPS)

Section 8 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

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

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2017, most journeys to the prison were short and support during prisoners' early days at the prison was reasonable. The prison was calmer than at the last inspection and the number of assaults had not increased. Antisocial behaviour was being more robustly managed. Security focused well on the presenting challenges but the positive drug test rate was high. Use of force was also high but appeared proportionate, although aspects of governance needed to be better. Few men were held in segregation for their own protection. Special cells were being used too often and for too long. There had been no self-inflicted deaths since the last inspection. Work was ongoing to improve support for the most vulnerable men, but the care provided was not consistently good enough. Adult safeguarding arrangements were underdeveloped. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

Special cells should only be used when necessary, and for the shortest time possible. (S44.)
Achieved

The prison needs to ensure that action identified in the comprehensive plan to address the availability and use of illegal drugs is carried out within the timescales outlined and any new threats identified and addressed promptly.
Partially achieved (S45.)

Recommendations

First night cells should be clean, functional and appropriately equipped. (1.12.)
Achieved

Men should be offered a free telephone call on arrival at the prison. (1.13.)
Achieved

The IEP scheme should be implemented in full, reviews carried out at appropriate times and prisoners on the basic level given sufficient support to improve their behaviour. (1.22.)
Not achieved

The prison should establish quality assurance procedures and lines of accountability for the use of force to ensure all incidents, including planned interventions, are reviewed promptly to assess if force was used proportionately and as a last resort. (1.27.)
Not achieved

Showers in the segregation unit should be refurbished. (1.32.)
Not achieved

Security objectives should be fully disseminated to all staff to ensure adequate feedback on areas of most concern. (1.37.)
Achieved

The prison should carry out all required suspicion drug tests. (1.38.)
Not achieved

ACCT documents should demonstrate that men were being appropriately cared for. (1.47.)
Partially achieved

Constant supervision processes should only be used when needed, and after alternatives have been explored. (1.48.)
Achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in [insert year], [insert HPS from last report]. Outcomes for prisoners were [insert performance judgement] against this healthy prison test.

Key recommendation

A plan about the closure and potential redevelopment of Rochester should be drawn up to provide the governor and prisoners with more clarity about the prison's future. (S46.)
No longer relevant

Recommendations

Prisoners should be held in adequately equipped cells within a decent residential environment. (2.14.)
Not achieved

Managers should address the prisoners' negative views of the food and seek ways to improve it. (2.19.)
Achieved

Prisoners should have ready access to confidential access complaint forms. (2.26.)
Achieved

DIRFs containing allegations about members of staff should be answered by an appropriately senior and sufficiently independent manager. (2.33.)
Achieved

Equalities peer workers should have a good understanding of the forms of support available for prisoners with protected characteristics and should interview prisoners in private. (2.34.)
Not achieved

The prison should investigate why black and ethnic minority men have negative perceptions of their treatment and develop a strategy to address the issues identified. (2.44.)
Not achieved

Senior health care managers should be fully involved with the prison management team. (2.59.)
Achieved

Prisoners should be able to complain easily about health services through a well-advertised single confidential system and responses should highlight escalation options. (2.60.)
Partially achieved

Waiting times for the optician should not exceed six weeks and for the GP, two weeks. (2.71.)
Partially achieved

Robust triage systems should be in place to ensure patients' needs are met in a timely manner. (2.72.)
Achieved

Suitable equipment and appropriate adaptations should be provided promptly. (2.78.)
Not achieved

A memorandum of understanding should be agreed formally between the prison and local authority to ensure men's social care needs are consistently met. (2.79.)
Achieved

Medicines should comply with labelling requirements, be stored safely and be transported around the prison securely. (2.107.)
Achieved

Discipline staff should regularly supervise all medicine administrations to ensure patient confidentiality and reduce the risk of bullying and trading. (2.108.)
Not achieved

Robust governance arrangements should be in place to monitor the quality of the dental service. (2.112.)
Not achieved

Purposeful activity

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

At the last inspection, in [insert year], [insert HPS from last report]. Outcomes for prisoners were [insert performance judgement] against this healthy prison test.

Key recommendation

The prison should ensure men have a good amount of time out of their cells every day and all men should have the opportunity during this time to engage in purposeful activities that support their rehabilitation. (S47.)
Not achieved

Recommendations

Prisoners should have access to at least one hour in the open air every day and exercise yards should contain seating and exercise equipment. (3.8.)
Not achieved

The prison should ensure all prisoners whose attainment in English and maths is below level 1 are encouraged to improve their skills and qualifications. (3.19.)
Not assessed at this inspection

Novus and the prison should ensure all training facilities are brought into use as soon as possible. (3.20.)
Not assessed at this inspection

The prison should introduce accredited functional skills training and support for men working in prison industries and workplaces. (3.21.)
Not assessed at this inspection

Managers should improve the use of individual learning plans and support teachers to ensure they are effective in helping learners progress. (3.29.)
Not assessed at this inspection

Vocational training should offer accreditation at level 2 and above where learners are able to achieve it. (3.30.)
Not assessed at this inspection

Novus should offer open and distance learning students support so they can improve their study skills. (3.31.)
Not assessed at this inspection

Prison workplaces should promote prisoners' employability by recognising and recording their personal and social skills. (3.38.)
Not assessed at this inspection

Managers should improve the poor outcomes on some English and maths courses. (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 [insert year], [insert HPS from last report]. Outcomes for prisoners were [insert performance judgement] against this healthy prison test.

Key recommendation

Prisoners should have an up-to-date OASys assessment and regular proactive contact with their offender supervisor. (S48.)
Achieved

Recommendations

Visits processes should be streamlined so that waiting times are reduced. (4.6.)
Achieved

Sentence plan targets should be specific and focus on reducing prisoners' identified risks. (4.22.)
Achieved

All officer offender supervisors responsible for prisoner casework should have casework supervision. (4.23.)
Achieved

The prison should ensure that all prisoners due for release and subject to MAPPA are reviewed and managed through the IDRMT. (4.24.)
Achieved

A suitable range of interventions and offending behaviour programmes should be available to meet the prison population's needs. (4.29.)
Not achieved

Prisoners should have access to sufficient debt management support at the prison. (4.30.)
Achieved

The prison should clarify how the prison should liaise with responsible officers in the community to ensure all relevant information about a prisoner's progress and ongoing needs is shared. (4.35.)
Achieved

Mentoring and Meet at the Gate support services should be developed to meet prisoners' needs. (4.36.)
Not achieved

Appendix I About our inspections and reports

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

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

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

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

Respect
Prisoners are treated with respect for their human dignity.

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

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

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

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

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

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

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

Our assessments might result in one of the following:

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

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

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

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

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

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

This report

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

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

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

Inspection team

This inspection was carried out by:

Martin Lomas	Deputy chief inspector
Deborah Butler	Team leader
Martin Griffiths	Inspector
Lindsay Jones	Inspector
David Owens	Inspector
Tamara Pattinson	Inspector
Kam Sarai	Inspector
Nadia Syed	Inspector
Charlotte Betts	Researcher
Rahul Jalil	Researcher
Alec Martin	Researcher
Isabella Raucci	Researcher
Sarah Goodwin	Lead health and social care inspector
Tania Osborne	Health and social care inspector
Sue Melvin	Pharmacist
Helen Lloyd	Care Quality Commission inspector
Judy-Lye Forster	Ofsted inspector
Tony Gallagher	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/

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

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

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

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

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

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

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

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

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

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

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

Appendix III Care Quality Commission Requirement Notice

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

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

Requirement Notice

Provider: Oxleas NHS Foundation Trust

Location

HMP/YOI Rochester

Location ID RPGAB

Regulated activities

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

Action we have told the provider to take

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

Regulation 17 (1)(2)(a)

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met

The systems and processes designed to enable the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk were not used effectively. In particular:

Clinical governance systems and processes were not robust. Not all incidents were being reported and not all staff were able to identify learning or service improvements introduced following the reporting of an incident. This meant that risks, trends and themes to identify gaps in patient care were not identified. For example, occasions when health care were not informed a patient had not been escorted to an external hospital appointment were not reported as an incident. This meant it was not possible to identify themes to support with influencing service improvements.

The reporting of medicine errors not meeting the significant incident criteria was low. Staff did not always recognise the significance of reporting errors. This meant that gaps in patient care were not always identified.

Governance processes did not always ensure the quality of the dental service. For example, the room adjacent to the dental suite did not comply with current IPC requirements. The floor had come away from the skirting, there was dust on top of the steriliser, and an extension lead resting next to the sink. Furthermore, a storeroom where the medicines cupboard was located was untidy.

A daily IPC checklist had not always been signed on the two days the dental clinic had taken place. Governance processes did not monitor compliance with the checklist completion. The flooring had not been reported for repair.

Appendix IV Further resources

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

Prison population profile

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

Prisoner survey methodology and results

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

Prison staff survey

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

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

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

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