Report on an unannounced inspection of

HMP Wormwood Scrubs

by HM Chief Inspector of Prisons

7–17 June 2021

Contents

Introduction

Wormwood Scrubs is a famous, category B, men's local prison in west London that held just over 1,000 prisoners at the time of our inspection, of whom a third were foreign nationals, more than half were black, Asian or minority ethnic and two-thirds were unsentenced. It has had a troubled recent history culminating in our 2017 inspection, when we described the 'intractability and persistence of failure at this prison'. When inspectors returned in 2019, they found a much-improved situation and I am pleased to say that this report shows that progress in many areas has been maintained. The prison feels calm and well-ordered and inspectors who knew the prison well noted a better atmosphere than in the past.

The prison was safer than at our last inspection. Assaults on staff and the use of force had continued to fall, while the rate of prisoner-on-prisoner assaults was one of the lowest of all local prisons. Data, though routinely collected, was not being used to analyse patterns of violence and create plans to achieve further progress in a prison that often saw gang and crime-related issues imported from the community. Reductions in violence were at least partly due to the fact that most prisoners had been locked in their cells for 23 hours a day and were at the expense of access to work, education and time to socialise. This was compounded for the 118 prisoners who had to share cramped, often ill-ventilated cells that were designed for one person, though the welcome introduction of in-cell telephones had at least allowed them to stay in regular touch with family and friends. Leaders at Wormwood Scrubs had not shown the ambition that we have seen elsewhere in increasing the amount of time prisoners were spending out of their cells.

With the support of the prison service, leaders have put much effort into improving the infrastructure of the prison with ongoing improvements to windows, serveries, the visits hall and showers. Officers were rightly proud of the cleanliness of their wings which, considering the churn in prison population, was mostly good.

It has always been difficult to recruit and retain staff members at this jail and at the time of inspection there was a large proportion of recently recruited officers who had not yet experienced anything like a normal regime. Staff training had fallen behind during the pandemic and hard work is needed to make sure that officers are fully prepared when the regime begins to open up.

The education provider had been too slow in reopening services and had done little to communicate with prisoners about the availability or range of courses. A lack of planning for a return to face-to-face education meant that classrooms were empty while prisoners were languishing behind their doors. Tutors had not made enough use of assessments to create in-cell education packs, meaning these were often of low quality and little use.

Leaders had been working to improve the quality and range of key work in the prison and, though more vulnerable prisoners were being seen regularly, there was much more to be done to make sure that every prisoner had meaningful

access. The Listener scheme (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) was particularly impressive and, where in some prisons this vital service had withered during the pandemic, at Wormwood Scrubs it had continued to thrive. Self-harm had reduced substantially and was already on a downward trend before the pandemic.

Overall, the prison was a much safer, cleaner and better organised prison than it had been in the past, but prisoners were locked in their cells for too long. The most important challenge facing leaders is to maintain and improve on the levels of safety, while significantly increasing the amount of time prisoners are spending out of their cells in education, training, work, leisure and rehabilitation activity.

Charlie Taylor
HM Chief Inspector of Prisons
June 2021

About HMP Wormwood Scrubs

Task of the prison/establishment
HMP Wormwood Scrubs is a reception and resettlement prison (category B, local) holding adult men and some young adults.

Certified normal accommodation and operational capacity (see Glossary of terms)
Prisoners held at the time of inspection: 1,079
Baseline certified normal capacity: 1,172
In-use certified normal capacity: 1,175
Operational capacity: 1,273

Population of the prison
- 1,664 new prisoners received each year (around 139 per month).
- 339 foreign national prisoners.
- 55% of prisoners from black and minority ethnic backgrounds.
- 64% of prisoners unsentenced.
- 147 prisoners released into the community each month.
- 263 prisoners currently receiving support for substance use.

Prison status (public or private) and key providers
Public

Physical health provider: Practice Plus Group Health and Rehabilitation Services Limited
Mental health provider: Barnet, Enfield & Haringey Mental Health Trust
Substance use treatment provider: The Forward Trust
Prison education framework provider: Novus; InHouse Records; Active IQ
Community rehabilitation company (CRC; see Glossary of terms): London CRC (MTC Novo)
Escort contractor: Serco

Prison group/Department
London

Brief history
Wormwood Scrubs was built by prisoners from Millbank Gaol between 1875 and 1891. In 1902, the last female prisoner was transferred to HMP Holloway. In 1922, one wing became a borstal. During World War II, the prison was used by the War Department. In 1994, a new hospital wing was completed, and in 1996 a fifth wing was completed.

Short description of residential units
- A wing (landings 1 and 2): Workers, remand and sentenced prisoners. It holds a maximum of 207 prisoners.
- A wing (landing 3): Protective isolation unit. It holds a maximum of 80 prisoners.
- B wing: Induction, reverse cohort unit (RCU; see Glossary of terms). It holds 167 prisoners.

- Jan Wilcox unit: Induction workers. It holds 17 prisoners, in double rooms and a dormitory. This is an annexe of B wing.
- C wing (landings 1 and 2): Workers, remand and sentenced prisoners. It holds a maximum of 138 prisoners.
- C wing (landings 3 and 4): Second-stage integrated drug treatment system. It holds a maximum of 165 prisoners.
- D wing (landings 1, 2 and 3): Workers, remand and sentenced prisoners. It holds a maximum of 180 prisoners.
- D wing (landing 4): Incentivised substance-free living unit. It holds a maximum of 64 prisoners, all in single rooms.
- E wing (landings 2 and 3): Workers, remand and sentenced prisoners. It holds a maximum of 91 prisoners.
- E wing (landing 4): Elizabeth Fry unit (EFU) and off-wing workers. It holds a maximum of 55 prisoners. The EFU supports those with learning difficulties and those engaging with in-reach.
- Health care unit: Holds a maximum of 17 inpatients.
- Conibeere unit: Detoxification/stabilisation unit and RCU. It holds a maximum of 55 prisoners.
- First night centre: Holds a maximum of 36 prisoners.
- Segregation unit: 18 single cells.

Name of governor/director and date in post
Jonathan French, June 2020

Leadership changes since the last inspection
Sara Pennington, September 2018 – March 2020
Amy Frost (deputy governor took up post, acting governor), March 2020
Sara Pennington April 2020 – June 2020

Prison Group Director
Ian Bickers

Independent Monitoring Board chair
Tanya Ossack

Date of last inspection
16 September – 4 October 2019

Section 1 Summary of key findings

1.1 We last inspected HMP Wormwood Scrubs in 2019 and made 34 recommendations, 13 of which were about areas of key concern. The prison fully accepted 27 of the recommendations and partially (or subject to resources) accepted five. It rejected two of the recommendations.

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

Progress on key concerns and recommendations

1.3 Our last inspection of HMP Wormwood Scrubs 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 three recommendations about key concerns in the area of safety. At this inspection, we found that one had been partially achieved and two had not been achieved.

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

1.6 We made four recommendations about key concerns in the area of purposeful activity. At this inspection, we found that one of those recommendations had not been achieved. Three of these key concerns were not inspected at this inspection.

1.7 We made four recommendations about key concerns in the area of rehabilitation and release planning. At this inspection, we found that one of those recommendations had been achieved, one had been partially achieved and two had not been achieved.

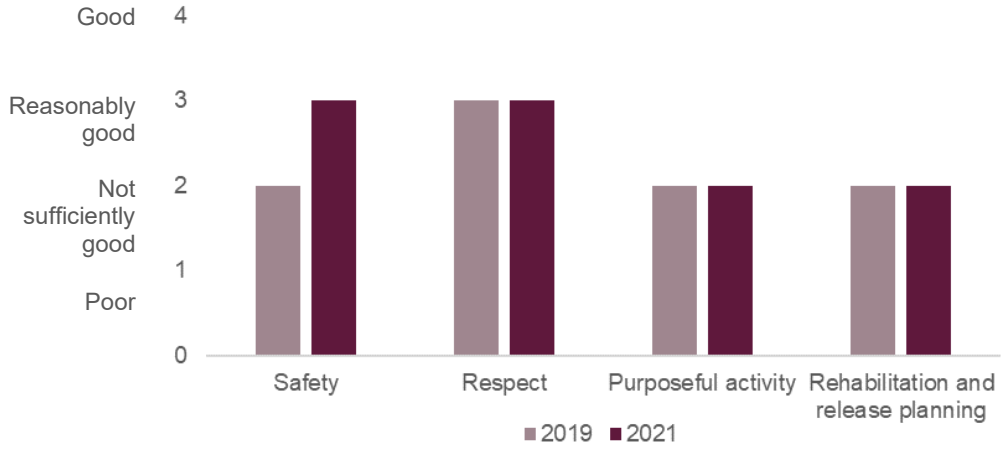
Outcomes for prisoners

1.8 We assess outcomes for prisoners against four healthy prison tests (see Appendix I for more information about the tests). At this inspection of HMP Wormwood Scrubs, we found that outcomes for prisoners had stayed the same in three healthy prison areas and improved in one.

1.9 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 Her Majesty's Prison

and Probation Service (HMPPS) National Framework for prison regimes and services.

Figure 1: HMP Wormwood Scrubs healthy prison outcomes 2019 and 2021



Safety

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

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

1.10 Initial risk screenings of prisoners by reception staff were brief and were not followed up with first night interviews, but health care reception assessments had improved. First night centre staff were approachable, and the induction was helpful.

1.11 There was a sense of order and calm in the prison. Levels of violence had reduced substantially. The safety strategy was comprehensive, but violent incidents were not always investigated thoroughly and there was limited use of case management procedures to address antisocial behaviour or to support victims.

1.12 Use of force had also reduced sharply, but a considerable amount of paperwork was outstanding and we saw little evidence of de-escalation. Batons had been drawn on seven occasions in the previous year, but paperwork indicated that this had been proportionate in each case.

1.13 The use of segregation had reduced and prisoners generally reported that they had been treated well by unit staff. Prisoners were usually reintegrated into the main population quickly and care planning for prisoners segregated for longer periods was good. The segregation unit was clean and prisoners had in-cell telephones. However, toilets had no seats or lids, and most cells had been fitted with fixed metal furniture.

1.14 Physical security arrangements were generally proportionate and aligned to risks, but some elements of procedural security were disproportionate, such as excessive handcuffing of prisoners on hospital escorts and routine strip-searching in reception and segregation.

1.15 A general theme across the management of violence, use of force, segregation and security was that good collection of data was not consistently followed by tangible action to help to improve outcomes further.

1.16 Levels of self-harm had reduced substantially and were lower than at comparable prisons. The implementation of assessment, care in custody and teamwork (ACCT) case management processes for prisoners at risk of suicide or self-harm was inconsistent, but these individuals reported positively on the care given to them. There had been three self-inflicted deaths since the previous inspection and not all Prisons and Probation Ombudsman (PPO) recommendations had been implemented effectively. In particular, each PPO investigation had highlighted similar failings during the early days in custody.

Respect

At the last inspection of Wormwood Scrubs in 2019, we found that outcomes for prisoners were reasonably good against this healthy prison test.

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

1.17 In our survey, 62% of prisoners said that staff treated them with respect. About a quarter of staff had only started work as prison officers during the pandemic. Prisoners told us that many staff were unable to deal with their queries, and we saw several examples of staff failing to challenge low-level rule breaking. Key work had been improving since March 2021 but remained inconsistent.

1.18 Communal areas and cells were generally clean and in reasonable repair, but poor cell ventilation, overcrowding and minimal time out of cell made conditions difficult. Prisoners had good access to showers and clean sheets, but there were ongoing problems with retrieving stored property. Cell call bell response times were improving and prison leaders had secured funding for an electronic monitoring system. Almost 80% of prisoners in our survey said that the food was bad. Meals were served too early and were provided in foil containers at cell doors rather than at serveries.

1.19 There was reasonably effective communication with prisoners, including through weekly newsletters and use of WayOut TV, and some consultation had taken place during the pandemic. Prisoners had little confidence in the complaints system, although oversight and analysis

had improved. A recently appointed bail information officer provided good support to prisoners.

1.20 Strategic oversight of equality and diversity had deteriorated during the pandemic. There was insufficient response to adverse equality monitoring data, and under-identification of prisoners with disabilities. However, in our survey, prisoners in protected groups reported broadly similarly to other prisoners, and good work had been done to encourage understanding of diversity through, for example, some excellent and informative prisoner-led discussions on WayOut TV.

1.21 The well-led, energetic chaplaincy had done good work to help mitigate the impact of COVID-19 restrictions on prisoners by visiting them every week, from the outset of the pandemic. Pastoral support was good and the team continued to provide bereavement counselling.

1.22 Health services were well led by a strong management team. Decisive and effective action had been taken to manage COVID-19 outbreaks and there had been no positive prisoner cases for four months. Most clinics had restarted and had reasonable waiting times. The management of long-term conditions had improved, but support for some patient groups was insufficient and care plans were not sufficiently personalised. The inpatient unit provided a good standard of care. Prisoners with social care needs were supported in the prison, but the local authority had not responded to prison referrals for over a year. An impressive range of mental health services was provided, but high referral rates had led to long waits for routine appointments. A large number of prisoners had severe mental health problems requiring transfer to external hospitals and most had waited too long to access a bed. Prisoners with drug and alcohol problems received adequate support despite pressures on clinical staffing.

Purposeful activity

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

At this inspection, we found that outcomes for prisoners remained not sufficiently good against this healthy prison test.

1.23 About 300 prisoners were in some form of activity, most of it full time, but those who were not working received only one hour out of cell each day for outdoor exercise, association and showers. Prisoners could still not visit the library and there was too little use or promotion of the book delivery service. Few prisoners were yet able to use the recently reopened gym.

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

1.25 In-cell education learning packs were of variable standard and leaders had not planned early enough for the return to face-to-face teaching. A newly opened restaurant allowed a small number of prisoners to gain skills and a qualification in hospitality and catering, but there were limited opportunities overall for prisoners to complete accredited courses.

1.26 The quantity and quality of information, advice and guidance given to prisoners on the wings were insufficient. Many prisoners did not know what courses were available to them and how to access them.

1.27 Tutors did not use the results of initial assessments well enough to inform individual learning support plans. The feedback given to prisoners on their learning packs was often unhelpful and did not support them to improve their work.

Rehabilitation and release planning

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

At this inspection, we found that outcomes for prisoners remained not sufficiently good against this healthy prison test.

1.28 The visits hall had been refurbished and provided excellent facilities. Social visits had resumed recently and were handled sensitively by visits staff. Although the take-up of 'Purple Visits' was fairly high, too many were cancelled as a result of staff shortages. The services of the Prison Advice and Care Trust (PACT) had been reduced, but the PACT family engagement worker continued to carry a substantial active caseload.

1.29 There was a thorough reducing reoffending needs analysis, but progress had been limited because of staff shortages and the uncertainties caused by the imminent reorganisation of resettlement services delivered by the community rehabilitation company (CRC). There were not enough middle managers, and several offender management unit (OMU) staff told us that they felt insufficiently supported in their work. There was good partnership working, and work across the resettlement pathways was well coordinated.

1.30 Although the backlog of offender assessment system (OASys) assessments had been reduced to reasonably low levels, only 10% of respondents to our survey were aware of a current custody plan. There was inconsistent and often very limited contact between prisoners and their prison offender manager. Most prisoners we spoke to said that it was difficult to contact the OMU.

1.31 Despite reduced staffing, the public protection team was experienced and committed, and completed necessary work on time. The number of prisoners on telephone monitoring was kept realistic through a tight

focus on risk. There was good communication between the prison and the community in relation to the highest-risk offenders.

1.32 There had been delays in categorisation procedures, but the backlog was improving. Progression was usually good, but those given category D status often had to wait several months for a transfer to open conditions, despite places being available. There was limited focus on the needs of indeterminate-sentenced prisoners, but monthly forums had recently restarted.

1.33 The recent needs analysis drew attention to the need to address offending behaviour for the substantial number of younger adults, many of whom may not have had the opportunity or sufficient time remaining in their sentence to be transferred to a category C training establishment. No offending behaviour programmes were available, but some useful short resettlement courses had continued to be delivered throughout the COVID-19 period by the CRC team.

1.34 There was a high level of housing need and, although few prisoners had been released homeless in the previous year, an average of only 61% had been released to permanent or settled accommodation. It was a concern that an imminent new housing contract did not include provision for the large remand population.

Key concerns and recommendations

1.35 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.

1.36 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.

1.37 Key concern: While initial assessments by health care staff had improved, the brief risk screening from reception staff was not followed up with an in-depth interview in the first night centre or reverse cohort unit to identify and address immediate needs and concerns. This was concerning, given that the PPO had been critical of the early days risk assessments preceding three self-inflicted deaths.

Recommendation: All new arrivals should have an in-depth first night interview that covers all risk factors, including self-harming behaviour.
(To the governor)

1.38 Key concern: Too much use of force paperwork was outstanding and both paperwork and available video footage suggested little evidence of de-escalation. Body-worn cameras were not routinely turned on during incidents, and recordings of unplanned incidents were not retained.

Recommendation: Prison leaders should ensure rigorous oversight and accountability in relation to the use of force, including through routine use of body-worn cameras and thorough completion of paperwork.
(To the governor)

1.39 Key concern: Many staff were inexperienced, had not worked in the prison outside of COVID-19 restrictions and were not confident in handling challenging behaviour. There was a large backlog in training.

Recommendation: Prison leaders should ensure that staff understand the needs of the prisoners they are supporting, and have the knowledge, skills and support to do this effectively.
(To the governor)

1.40 Key concern: Too many cells designed for one were still being shared by two prisoners. This longstanding problem had persisted despite prison leaders' efforts to obtain approval from HMPPS to convert them to single accommodation.

Recommendation: Two prisoners should not be held in cells designed for one person.
(To the governor and HMPPS)

1.41 Key concern: There was poor identification of prisoners in protected groups, particularly those with disabilities. Insufficient consideration of monitoring data, together with the suspension of consultation, did not provide assurance that need was properly understood. Even when identified, some evidence of consistent disproportionate treatment was not acted on adequately. For example, there had been no action in response to monitoring data showing disproportionate use of force on, and segregation of, black prisoners.

Recommendation: Prisoners in protected groups should be identified systematically and consulted regularly. Monitoring data which shows disproportionate findings should be investigated and result in suitable actions where necessary.
(To the governor)

1.42 Key concern: Most prisoners were locked in their cells for 23 hours a day, which had a serious impact on their wellbeing. Leaders were taking a cautious approach to improving the inadequate regime, partly because of staff inexperience, but time out of cell could have been improved with current staff numbers and experience, even in the context of the pandemic. There was a lack of clear planning for regime recovery.

Recommendation: Prison leaders should set out a roadmap for substantially increasing prisoners' time out of cell and participation in activity, with clear milestones that are understood by prisoners and staff.
(To the governor)

1.43 Key concern: In our survey, only 10% of prisoners said that they had a custody plan, and although there was some good offender management work, it was not consistent and there was not enough contact with prisoners. Some key management posts in the OMU had been vacant for some time and there was a lack of positive day-to-day leadership. Several OMU staff told us that they felt insufficiently supported in their work.

Recommendation: Day-to-day leadership in the offender management unit should be strengthened and leaders should ensure that the provision of offender management services is comprehensive and consistent.
(To the governor)

Notable positive practice

1.44 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.

1.45 Inspectors found seven examples of notable positive practice during this inspection.

1.46 The bail information officer identified and supported prisoners who were eligible to apply for bail, providing a useful and proactive service to the large number of remand prisoners at the establishment. (See paragraph 3.21.)

1.47 The prison made particularly good use of WayOut TV to keep prisoners informed and stimulate debate through a range of thoughtful filmed presentations involving staff and prisoners alike. Content included equality and diversity-related discussions, and celebration of religious festivals and events such as Black History Month. (See paragraphs 3.17, 3.34, 3.45 and 3.51.)

1.48 The chaplaincy had worked energetically to mitigate the impact of COVID-19 restrictions by conducting weekly welfare visits to all prisoners. (See paragraph 3.51.)

1.49 The team of occupational therapists in the Seacole day centre provided particularly good practical and emotional support to individuals with neurodiverse needs. (See paragraph 3.91.)

1.50 A pharmacist was now placed on the first night centre, to review medicines at an early stage. This had led to earlier identification of prisoners with complex needs and addressing of any discrepancies with medication. (See paragraph 3.106.)

1.51 Prison leaders had taken a leading part in a pilot project in London prisons, to provide confirmation of identity to prisoners who did not

have this, in order to access accommodation and benefits. (See paragraph 5.30.)

Section 2 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

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

2.1 There continued to be long delays at court, with prisoners often waiting several hours before departing for Wormwood Scrubs, and late arrivals at the prison were a regular occurrence. There had been good and largely successful efforts to reduce waiting times on arrival at the prison, although about 6% of arrivals in the previous month had waited for five hours or more before moving to a residential unit. Prisoners' warrants were often not received electronically before their arrival, extending paperwork checks and causing delays.

2.2 New arrivals were handcuffed from escort vehicles to reception only on the basis of a risk assessment. However, despite the introduction of a body scanner, all prisoners coming into and going out of the prison continued to be routinely strip-searched (see recommendation 2.33).

2.3 Prisoners entered a reasonably welcoming reception area, where the risk of virus transmission was minimised through the wearing of face masks and the use of reduced capacity holding rooms. Most communal areas were clean, but holding rooms were dirty and bare.

2.4 The Prisons and Probation Ombudsman (PPO) had raised concerns about early days risk assessment procedures in relation to three self-inflicted deaths that had taken place since the last inspection (see key concern and recommendation 1.37 and section on suicide and self-harm prevention). All of the individuals concerned had been relatively new to custody and had serious mental health problems. Partly in response to this, considerable work had been undertaken to improve the assessment and care of new arrivals by health care staff, although there were some difficulties in ensuring that interviews were always private (see paragraphs 3.58 and 3.72). However, initial risk screenings completed by reception staff were brief and not followed up with more in-depth interviews in the first night centre (FNC) or the reverse cohort unit (RCU). Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) were present in reception, as well as prisoner orderlies who supported staff with daily tasks.

2.5 The FNC consisted of dormitory accommodation as well as single and double cells. It provided a reasonably welcoming environment, and

staff were friendly and approachable. The peer-led induction covered essential information well, and a more in-depth programme was planned as the pandemic restrictions were eased. A telephone call was provided to new arrivals and welfare checks were conducted every hour during the first night. Most prisoners remained in the FNC for their first night only, before being moved to the RCU. In some cases, prisoners remained on the FNC because of their vulnerability; at the time of the inspection, there were eight such prisoners. These prisoners received only one hour out of their cell daily (see also paragraph 4.1, and key concern and recommendation 1.42).

2.6 Once on the RCU, prisoners self-isolated for seven days. RCU cells were not always prepared to a good standard. For example, two cells that were deemed ready for occupation – and were due to be filled immediately after we viewed them – were dirty, with an abundance of graffiti and large amounts of rubbish from the previous occupants.

2.7 Time out of cell (see Glossary of terms) on the RCU was very limited and prisoners received only 30 minutes out of their cell each day.

Recommendation

2.8 **Strip searching on arrival at the prison should be carried out only on the basis of an individual risk assessment and always in a private space.**

Managing behaviour

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

Encouraging positive behaviour

2.9 There was a sense of order and calm in the prison. Recorded levels of violence against staff and prisoners had decreased substantially since the previous inspection, although there was some under-reporting and emerging evidence that violence was beginning to increase. In the previous 12 months, there had been 165 assaults against prisoners and 132 against staff. These figures included 18 serious assaults against prisoners and 15 against staff. In our survey, 23% of respondents said that they currently felt unsafe.

2.10 The safety strategy was comprehensive and all violent incidents were investigated. However, in the incidents we reviewed, investigations lacked rigour and paperwork often contained information which had been cut and pasted from other reports. By contrast, the quality of serious incident investigations was good and resulted in suitable action, although we found one case which should have been investigated as a serious incident but was not.

2.11 Challenge, support and intervention plans (CSIPs; see Glossary of terms) were not used to full effect. In the previous 12 months, only 11 CSIPs had been opened. There was an over-reliance on the incentives scheme and adjudication process for perpetrators of violence or antisocial behaviour. A weekly safety intervention meeting discussed those identified as presenting a high risk of concern but did not always consider all relevant prisoners. Minutes we examined also lacked evidence of meaningful discussion and action.

2.12 There was no formal support for victims of violence. 'Belong', a restorative justice service, worked with prisoners who were willing to engage in mediation.

2.13 There was a comprehensive incentives strategy, although in our survey only about a third of prisoners said that it influenced their behaviour. There were only nine prisoners on the basic regime at the time of the inspection. However, the cases we reviewed did not have daily entries, as indicated in the local policy, and none had progressed after seven days; all remained on basic regime for a minimum of 14 days. Not all case reviews were recorded, and prisoners were not always involved in the review process.

Recommendations

2.14 **All violent incidents should be reported on the incident management system.**

2.15 **Leaders should ensure that the challenge, support and intervention plan process is used effectively for perpetrators of violence, and that formal support is in place for victims.**

Adjudications

2.16 There had been 2,694 adjudications in the previous 12 months, fewer than at the time of the previous inspection. Too many were not proceeded with or were dismissed because of procedural errors, sometimes for serious offences.

2.17 The records that we sampled showed that prisoners were given enough time to prepare for hearings and request legal assistance. However, in the sample that we reviewed, too often there was a finding of guilt with insufficient investigation. The deputy governor quality-assured a sample of adjudications and observed the process randomly.

2.18 Useful data were gathered and presented at the adjudication standardisation meeting, but there was a lack of subsequent actions.

Recommendation

2.19 **Adverse adjudications data should be acted on to ensure that adjudications are conducted promptly and to a demonstrably high standard.**

Use of force

2.20 There had been 659 uses of force in the previous 12 months, far fewer than at the time of the last inspection. Batons had been drawn on seven occasions during this period and used twice; the paperwork indicated that this had been proportionate in each case. All incidents involving batons were reviewed by the control and restraint coordinator, but not by senior managers.

2.21 Use of force records indicated a number of shortcomings: paperwork was often outstanding, de-escalation techniques were not well documented, the risk of COVID-19 transmission was not considered and not all prisoners involved in use of force incidents were reviewed by health care staff. In our review of recorded planned incidents, we found that de-escalation techniques were not always used before and during an incident; in one case, there were serious shortcomings in practice, which were passed to senior leaders for review and lessons to be learned (see key concern and recommendation 1.38).

2.22 Recordings of all planned incidents were retained, but video footage of unplanned uses of force were not. Despite the availability of body-worn cameras, they were not always turned on during incidents and there was a lack of data to show how widespread this issue might have been (see key concern and recommendation 1.38).

2.23 Most use of force incidents were reviewed weekly by the deputy governor and some lessons were being learned. However, the monthly use of force committee meeting demonstrated little evidence of effectiveness. Data were not scrutinised sufficiently and outstanding actions often rolled over from month to month without progress, including one on the underuse of body-worn cameras (see also paragraph 3.33 and key concern and recommendation 1.38).

2.24 The use of special accommodation had decreased, with seven uses in the previous 12 months. The average stay was one hour 14 minutes, with the longest being two hours 47 minutes. The paperwork we examined did not always demonstrate sufficient justification for its use, and some records indicated that the use was punitive, with references to ‘a period of calm’ or ‘for a period of compliance’. All uses of this accommodation were reviewed by the deputy governor, who had identified some of the issues that we found, but it was not clear what action had been taken.

Recommendation

2.25 **Special accommodation should be used only in the most exceptional circumstances and not punitively. Records of its use should be detailed and include justification.**

Segregation

2.26 Since the previous inspection, there had been a decrease in the use of segregation, with 471 uses in the previous 12 months. The average

length of stay was approximately 9.5 days. In our survey, about two-thirds of those who had been segregated said that they had been treated well by staff on the unit.

2.27 The documented reasons for segregation were mostly lacking in detail. Behaviour targets were often superficial and entries in ongoing records were observational and did not demonstrate meaningful interaction. Segregation paperwork was not quality assured and was therefore confusing and disorganised.

2.28 The segregation unit was clean and all cells had telephones. However, most cells had been fitted with fixed metal furniture, and toilets were ingrained with dirt and did not have seats or lids. The regime was poor, with prisoners having only 30 minutes a day out of their cell for exercise and a shower; we were told that this could be increased if staffing levels allowed. The two exercise yards used by the segregation unit were bleak and had graffiti on the walls.

A cell on the segregation unit

The toilet and sink facilities in a cell on the segregation unit

2.29 Prisoners were strip-searched routinely on arrival to the segregation unit. This took place in the special accommodation cell, which was inappropriate as the cells contained closed-circuit television cameras.

2.30 Prisoners who stayed for more than 30 days on the unit had a care plan. These were of a reasonable quality and considered the prisoner's mental wellbeing, behaviour and plans for reintegration. There was no care planning for those with shorter stays.

2.31 Useful data were gathered and presented at the segregation monitoring and review group meeting, but it was not clear how this information was used to plan future actions and effect change.

Recommendations

2.32 **Segregation paperwork should detail fully the reasons for segregation, and the ongoing record should demonstrate regular, meaningful interaction with those segregated. Paperwork should be quality assured by a senior leader.**

2.33 **Strip-searching on entry to the segregation unit should be carried out only on the basis of an individual risk assessment and always in a private space.**

Security

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

2.34 Physical security arrangements were generally proportionate and aligned to risks, although some elements of procedural security were excessive (see paragraphs 2.2 and 2.29, and recommendation 2.33). Restraints used to escort prisoners on appointments outside the prison were not always justified by risk; for example, a 75-year-old prisoner in a wheelchair was handcuffed to an officer on a number of occasions for attendance at hospital appointments. The PPO had previously noted concerns about this practice.

2.35 The ongoing replacement of windows on residential units contributed to the enhancement of physical security.

2.36 The number of intelligence reports submitted had decreased, with an average of 390 a month. These were analysed, collated and disseminated well, but we found some evidence of under-reporting. The insufficient flow of intelligence was a longstanding problem and security managers were introducing new initiatives, including designated security liaison officers, to raise awareness and support new and less experienced staff.

2.37 Leaders were aware that the ingress of illicit substances, weapons and mobile phones were the key threats they faced. Many targeted searches led to finds of illicit items. In the previous 12 months, searches across the prison had resulted in 282 drug finds and the recovery of 280 mobile phones and 172 weapons.

2.38 Technology was used well to enhance safety and support the reduction of illicit items. The machine to detect drugs coming in through the mail,

and the body scanner to detect and deter the trafficking of illicit items into the prison were used effectively.

2.39 In our survey, 29% and 19% of respondents said that it was easy to get illicit drugs and alcohol, respectively, in the prison. Mandatory drug testing (MDT) had not taken place since before the start of the pandemic. Leaders had decided to suspend the return to MDT in January 2021 because it would have entailed diverting limited staff resource from prisoner care and there was evidence that drug supply had reduced during the pandemic. This was an understandable short-term measure, but it meant that the establishment lacked important data on drug use, and that the potential deterrent effect of MDT was not being used.

2.40 The monthly local tactical assessment was good and provided an overview of key security concerns from the previous month. Monthly security meeting minutes were brief and did not demonstrate enough analysis of the available data or always identify actions to make sure that concerns were addressed.

2.41 There was a published substance misuse strategy and the associated action plan was comprehensive. There was a monthly drug strategy meeting and there was some evidence that this addressed identified actions.

2.42 Prison leaders worked effectively with the police when staff wrongdoing was suspected, and this had yielded some positive results. There was also good inter-agency involvement to help in the management of gang problems and potential extremism.

Recommendation

2.43 **The handcuffing of prisoners on escort should be based on a full risk assessment and be proportionate to the risks posed.**

Safeguarding

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

Suicide and self-harm prevention

2.44 There had been three self-inflicted deaths since the previous inspection. In each case, PPO investigations had highlighted failings during the early days processes (see paragraph 2.4 and key concern and recommendation 1.37). Prison leaders had good oversight of PPO recommendations (see also paragraph 3.58) but learning from some was slow. For example, a ‘notice to staff’ on lessons learnt from deaths

in custody sent out in January 2020 was almost identical to another notice issued in May 2021, suggesting minimal progress.

2.45 Levels of self-harm had reduced substantially. In the previous 12 months, there had been 247 incidents, which was lower than at all comparable prisons. Self-harm levels had been on a downward trend before the start of the regime restrictions. Prison leaders had taken action to rectify under-reporting of incidents to Her Majesty's Prison and Probation Service nationally, with daily cross-referencing of self-harm incidents against the national recording tool.

2.46 The safety strategy was comprehensive and current. It described the safety 'journey' over last few years and included learning points, good practice and improvements made. This was accompanied by a safety action plan, which addressed future development, including learning from PPO investigations.

2.47 Safety-related meetings were held regularly and were multidisciplinary. Data collation was generally good, but discussions about trends and patterns were not recorded and subsequent actions to improve outcomes were limited.

2.48 In our survey, 65% of respondents who had been subject to assessment, care in custody and teamwork (ACCT) case management procedures said that they had felt cared for by staff, which was much better than at the time of the previous inspection (26%). The sample of ACCT documentation we viewed was of mixed standard. While some records showed attendance from health care staff and effective care plans, many records were incomplete and had poor care maps. This was being addressed through quarterly assurance reviews by the head of safety. Prisoners with more complex needs received good support and regular welfare checks.

2.49 At the time of the inspection, there were 31 Listeners and access to them was generally good. The Samaritans supported the team and attended every week for a two-hour meeting, which was well attended.

Protection of adults at risk (see Glossary of terms)

2.50 A safeguarding policy was in place, but it was very brief and did not state clearly what made an adult vulnerable or the actions to take if there was suspicion of abuse, risk or neglect.

2.51 Prisoners who had difficulty with coping in other parts of the prison were usually held on the Elizabeth Fry unit, which provided greater support for them. A remand prisoner on the unit had been self-isolating for over a month because of threats made against him, but had not been highlighted as vulnerable or discussed at the weekly safety intervention meeting. This was rectified when we raised it.

2.52 The head of safety acted as the safeguarding lead for the prison. The prison had good links with the local safeguarding adults board, with regular attendance at community meetings. Since 2020, a total of four

referrals had been made to the board for further investigation, one of which had been instigated by the prison itself.

Section 3 Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

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

3.1 In our survey, 62% of respondents said that staff treated them with respect, and the same proportion said that there was a member of staff they could turn to with a problem. We saw many examples of staff–prisoner interactions that were supportive and engaged, and most prisoners we spoke to could identify helpful members of staff on their wing. However, we also saw frequent incidents of staff failing properly to challenge low-level rule breaking, such as prisoners vaping on the landings, swearing and not wearing shirts on the exercise yards. On some wings, staff were clustered together in and around wing offices, and were not always immediately visible to prisoners.

3.2 Twenty-six per cent of the prison's operational staff had been in post for less than 18 months. Many officers had never worked in the prison outside of COVID-19 conditions and needed additional support to navigate the return to normal conditions. Many prisoners told us that inexperienced staff were less able to deal effectively with problems, and some staff told us that they lacked the confidence to enforce rules and handle complex situations (see key concern and recommendation 1.39). This was exacerbated by the limited amount of time out of cell (see paragraph 4.1), which meant that staff were sometimes overwhelmed by the volume of prisoner requests during association time. There was a large training backlog among prison staff. In order to help operational staff prepare for the easing of restrictions, prison leaders had conducted an analysis of the training needs of staff, and had planned monthly afternoons of 'speed' training to cover issues such as searching and the use of restraint, but this had not yet started at the time of the inspection.

3.3 Little key work (see Glossary of terms) had taken place before March 2021. In March, leaders promoted a 'golden month' of key work, allocating additional resources and encouraging staff to appreciate its value. There had been considerable improvements since then, but only 38% of prisoners were currently allocated a key worker who contacted them regularly to support their welfare and progression. Many were contacted by different members of staff for each session, which impeded the building of rapport. The prison gave appropriate priority to vulnerable and higher-risk prisoners (such as those on assessment, care in custody and teamwork (ACCT) case management or Terrorism Act prisoners), who were generally seen every week. Most of the other

records we checked showed fewer regular sessions taking place, and some prisoners had had only had one contact since March. Leaders quality-assured key worker entries, but these remained of variable regularity and quality.

Recommendation

3.4 **Prison leaders should continue to develop the key work strategy, to ensure that each prisoner has regular and high-quality contact with a key worker.**

Daily life

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

Living conditions

3.5 The improvement in the standard of accommodation we had observed at the previous inspection had been maintained. Some older accommodation was in a poor state of repair, but most cells and communal areas were clean and in decent condition, and there was only a limited amount of graffiti and damage. There had been major efforts to refurbish the prison, and these had continued during the pandemic. This included a rolling, prisoner-led refurbishment of cells; upgrading showers and serveries; the replacement of windows; and completion of the installation of in-cell telephony across the prison. The new vented windows had gone some way towards reducing the amount of litter thrown into exercise yards, but vents could become blocked and had led to problems with ventilation and temperature control.

A typical wing

A typical exercise yard

The outside grounds area

3.6 Leaders had continued to conduct decency checks during the pandemic, although less regularly than in normal conditions. Wing staff checked cells, and problems with missing items and repairs were addressed in a timely manner.

3.7 Prisoners could shower every day and did not report any problems with their ability to keep their cells clean and tidy. Cleaning materials, clean sheets and laundry facilities were available on all wings.

3.8 Too many prisoners continued to live in overcrowded conditions. One-hundred-and-one cells designed for one person were certified for use by two prisoners (11% of the total). At the start of the inspection, 59 of these cells were in use, housing 118 prisoners. This longstanding problem had persisted despite prison leaders' efforts to obtain approval from Her Majesty's Prison and Probation Service to convert them to single accommodation. These cells did not have a separate bathroom and had only a screen to separate the toilet from the beds and living area. Prisoners who shared cells told us that these conditions had proven challenging during the pandemic, when they had been locked in their cells routinely for as many as 23 hours a day (see key concern and recommendation 1.40).

3.9 There was still no systematic record of cell call bell response times. However, in our survey, more respondents than at the time of the last inspection said that their cell call bell was normally answered within five minutes, and we saw many being answered promptly. The prison had

secured funding for an electronic record system to monitor cell call bells and response times, which was scheduled to be installed in 2022.

3.10 Only 21% of prisoners in our survey said that they could access stored property, and many told us of delays with this. This was due to problems with couriers who delivered parcels to the prison and a surplus of property at reception, and meant that some prisoners waited for long periods for items to reach them. Prison leaders had recently carried out work to identify solutions to these issues, but these had yet to be implemented at the time of the inspection.

Recommendation

3.11 **Prisoners should be able to access their property promptly following request.** (Repeated recommendation 2.15)

Residential services

3.12 In our survey, almost 80% of respondents described the food as quite or very bad, and many said that they did not have enough to eat. On one wing, we found a food comments book held by a prisoner orderly which had recorded over 100 complaints in one month. The menu had been restricted during the pandemic because of limitations on the number of workers permitted in the kitchens. Prison leaders recognised food as an area that required improvement and had established a working group to consider ways to address the issue.

3.13 Meals were still being served to prisoners at their cell doors, in foil takeaway containers, as part of the prison's infection control measures, and continued to be served too early. Prisoners told us that this often meant that food was delivered cold, further reducing the quality. There was some reluctance among staff to return to serving meals at the serveries on the wings, but prisoners told us that this was something they were keen to see happening.

3.14 All prisoners working in the kitchens had now completed food safety training, which was an improvement since the previous inspection.

3.15 The prison shop sold a wide range of goods, and prices were reasonable. Prisoners were generally positive about the shop and could also order clothing and electrical items from a range of catalogues. However, they were now required to buy credit for their in-cell PIN telephones via their weekly shopping order, which led to some of them running out of credit later in the week and unable to buy more until the next shop order. Some wings allowed prisoners to buy an 'emergency' top-up, but this was not consistent across all wings.

Prisoner consultation, applications and redress

3.16 Prisoner consultation had continued during some of the pandemic via the prisoner council, and this had been regular since November 2020, although the group had seen reduced attendance due to COVID-19 restrictions. The minutes from these meetings showed that senior staff provided prisoner representatives with good updates on developments

in the prison, and that prisoners were able to raise issues of concern freely. Some actions were generated, but follow-up to these actions was not always evidenced.

3.17 The prison had made good use of WayOut TV and weekly newsletters to keep prisoners informed during the pandemic. The newsletters included an update from the governor, and a space for prisoners to submit comments to staff in response, which was positive.

3.18 In our survey, 72% of respondents said that it was easy to make an application, and 59% of these said that applications were dealt with fairly. Application forms and submission boxes were freely available on the wings. The prison had no data on, or systematic way of recording, the number of applications received or their response times; however, the applications we saw had generally been resolved in a timely and appropriate manner.

3.19 Legal visits had resumed. They took place, both in-person and via video calling, in a large suite of rooms. These were private and in good condition. The visits area also had two confidential 'boxes' for video calls to take place; these were used for police interviews and sensitive matters. Video-link facilities for court appearances were also available. The wait for legal visits could sometimes be long – in part, due to recent restrictions to legal visits during the pandemic. The prison still did not have a member of staff who was responsible for overseeing prisoners' access to legal rights.

3.20 A range of legal resources was available in the prison library, but, as the library was closed to prisoners (see paragraph 4.3 and recommendation 4.6), access to computers on which they could type legal correspondence had been curtailed. Three prisoners were using 'access to justice' laptop computers at the time of the inspection.

3.21 The prison had recently appointed a bail information officer, who was doing valuable work in identifying prisoners who might be eligible to apply for bail, and communicating the process to them. This officer also wrote reports which were submitted to the courts, outlining prisoners' accommodation needs, financial situation and other pertinent information. Given the rising number of remand prisoners at the establishment, this was a useful resource.

3.22 The prison did not encourage voting registration for prisoners who were eligible and had not provided them with any information about their voting rights.

3.23 In the 12 months before the inspection, the prison had received 1,616 complaints, which was a reduction on the previous year. In the sample we looked at, the responses were generally timely, polite and addressed the issues at hand. However, we found a small number of complaints which had not been responded to, and responses which had been unhelpful and curt. Complaint forms were available on each of the wings.

3.24 Oversight and analysis of the complaints system had improved. Senior leaders quality-assured a sample of complaint responses each month. In addition, a new member of staff had been given responsibility for overseeing the analysis of complaints; this had resulted in the prison developing good data on the causes of complaints and the number submitted by prisoners with protected characteristics. However, the prison did not record the number of complaints which were upheld and overturned. There were plans for these data to be discussed during senior management team meetings, which would allow for discussion of how to address issues that were the common topics of complaints.

3.25 Despite these improvements, prisoners had little confidence in the complaints system. In our survey, less than half of respondents said that it was easy to make a complaint, and 40% said that they had been prevented from making a complaint. Many prisoners told us that they felt there was little point in complaining as they did not feel it would result in any change.

Recommendations

3.26 **The prison should monitor application numbers and response times systematically.**

3.27 **The prison should investigate prisoners' lack of confidence in the complaints system and the reasons for the large numbers reporting that they have been prevented from complaining, and act on the findings.**

Equality, diversity and faith

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

Strategic management

3.28 Strategic oversight of equality and diversity had been affected adversely by the COVID-19 restrictions. The diversity and equality action team (DEAT) had continued to meet, but the suspension of consultation with prisoners in protected groups and generally poor consideration of monitoring data had undermined its effectiveness. The ability of the prison to monitor the treatment of prisoners in protected groups was compromised by poor identification of such prisoners, particularly those with disabilities (see key concern and recommendation 1.41, and paragraph 3.40).

3.29 The action plan made good provision for some groups. However, there had been slow progress on implementing the plan during the

pandemic, and few substantive actions were generated in DEAT meetings. There was little in the action plan for older prisoners and those with disabilities, which were serious omissions.

3.30 There was now a full-time equality adviser, who was a visible presence in the prison and identified some needs. There were well-supported prisoner representatives for each wing, although limited time out of cell during the pandemic had imposed constraints on what they could achieve. These representatives were to be trained by the Zahid Mubarek Trust, although training had been delayed because of the COVID-19 restrictions in the prison.

3.31 Only 10 discrimination incident report forms (DIRFs) had been submitted in the previous six months, which suggested limited awareness or confidence in the system. The quality of responses to the submitted DIRFs was mostly adequate, although not all were responded to promptly.

3.32 Despite weaknesses in the management of equality work, in our survey prisoners in protected groups reported broadly similar treatment and conditions to their counterparts on most questions. The prison had a diverse workforce and had been doing some good work to improve the representation of black and minority ethnic staff in more senior roles.

Protected characteristics

3.33 Fifty-one per cent of the population was from a black and minority ethnic group. Monitoring data showed no disproportion in these prisoners' access to the very limited work opportunities during the pandemic. However, the prison had identified, but not adequately addressed, consistent evidence of disproportionate use of force on, and segregation of, black prisoners (see key concern and recommendation 1.41).

3.34 Despite the COVID-19 restrictions, some excellent work had been done to celebrate Black History Month, with prisoners involved in a series of video presentations shown on WayOut TV. The health care department had done some good work to address vaccine hesitancy among black and minority ethnic prisoners (see paragraph 3.67).

3.35 The chaplaincy facilitated contact with the Irish Chaplaincy, a charity providing support for Irish Travellers and Gypsies, although not all prisoners were aware of the provision. The surgeries that had previously been run by the Irish Chaplaincy remained suspended.

3.36 There were 321 foreign national prisoners, representing 29% of the population. Foreign national prisoners reported broadly similar treatment and conditions to others in our survey. However, there had been no consultation with them since the last inspection, and no monitoring data on their treatment were collated.

3.37 Staff spoke a wide range of languages and good use was made of their skills to interpret for prisoners. However, other than in health care,

there was little evidence of the use of professional telephone interpreting services, and we found some instances where interpretation had not been used when necessary. Progress had been made in translating information for prisoners, but important information, such as that provided on induction, was still only available in English.

3.38 At the time of the inspection, 28 prisoners were being held under immigration powers after completing their sentence. Three immigration detainees had been held since 2019, which was far too long. The prison had recently arranged for a charity, Detention Action, to provide support for detainees. However, there was little access to free legal representation and poor awareness of the legal support charity, Bail for Immigration Detainees. Unlike in immigration removal centres, the Legal Aid Agency did not provide detainees with access to immigration legal advice surgeries, a failing which the High Court had recently found to be unlawful. Immigration officers based at the prison continued to see prisoners face to face, but prisoners told us that often officers could not give them any meaningful information about how their cases were progressing.

3.39 The Home Office had not informed the prison that it had assessed some detainees to be at risk under its policy, Adults at Risk in Immigration Detention. The policy, introduced in 2016, is intended to contribute to a reduction in the number of vulnerable people in detention, and in the length of their detention before removal. As we have found in other inspections, prison staff had not heard of the policy, and there had therefore been no consideration about whether detainees assessed to be at risk should be subject to care plans.

3.40 There was poor identification of prisoners with disabilities; for over half the population, the prison had no record of whether or not they had a disability. The failure to collect accurate data identifying prisoners with disabilities, and Social Services' suspension of social care assessments, did not provide assurance that the needs of prisoners in this group were understood sufficiently. Consultation forums for prisoners in this group remained suspended (see key concern and recommendation 1.41). Most prisoners with disabilities we spoke to reported reasonable treatment by staff, but we found some evidence of unmet need.

3.41 Prisoners with a personal emergency evacuation plan were well identified to staff. However, some staff on night duty were unaware of the plans when asked and not all plans were up to date or provided sufficiently clear arrangements for evacuation. There was insufficient oversight of informal arrangements for volunteers to help with tasks such as cell cleaning and the collection of food.

3.42 Health care staff provided good support to prisoners with learning disabilities, and some work was under way to improve wing provision for such prisoners.

3.43 Forums for older prisoners remained suspended, together with other provision, such as dedicated gym sessions. There was little attention in the action plan for prisoners in this group.

3.44 While prisoners aged 25 and under reported similar treatment and conditions to others on most questions in our survey, they were less positive in relation to some questions concerning their interactions with staff. For example, only 45% said that most staff treated them with respect, compared with 68% of older prisoners. There was insufficient attention to data on the treatment of younger prisoners, which showed that they were less likely to be on the enhanced level of the incentives and earned privileges scheme, and to make a complaint. The prison recognised the need to develop provision for prisoners in this group and we were pleased to see that leaders were considering initiatives such as the development of maturity assessments and targeted education and work.

3.45 Despite some good work to promote LGBT awareness, only three prisoners had disclosed that they were gay. The prison had recorded an excellent, informative interview with the two transgender prisoners at the prison, which was screened on WayOut TV throughout LGBT awareness week. These prisoners reported generally good treatment from staff and felt safe in the prison. The prison had agreed appropriate compacts dealing with matters such as showering and searching for transgender prisoners. However, recent local case board reviews had been held with both prisoners present, which did not provide for confidentiality.

Recommendations

3.46 **Professional interpreters should be used where necessary to support accurate and confidential communication.**

3.47 **The Home Office should inform the prison promptly of all immigration detainees assessed to be at risk in detention.**

3.48 **Immigration detainees should have access to free, independent legal advice surgeries.**

3.49 **Paid carers should be available to provide additional support to prisoners with disabilities, and they should be subject to appropriate oversight and supervision.**

3.50 **Prisoners with specific evacuation needs should have a clear and up-to-date personal emergency evacuation plan, which is known to all wing staff, including those working at night.**

Faith and religion

3.51 The well-led chaplaincy covered all the faiths practised by prisoners. It had worked energetically to mitigate the impact of COVID-19 restrictions by conducting weekly welfare visits to all prisoners. Faith resources, such as sermons and scriptures, were updated regularly and made available to prisoners, including those who were shielding

(see Glossary of terms) or isolating. Good use was made of WayOut TV to communicate with prisoners and celebrate religious festivals.

3.52 During the inspection, the prison had begun to resume classes in religious instruction and some programme work. However, compared with others we have visited recently, the prison was slower to resume corporate worship, which was not expected to happen until July 2021. Despite this and other ongoing restrictions, in our survey 69% of respondents said that their religious beliefs were respected, similar to the proportion at the time of the last inspection. Similarly, despite Ramadan taking place during the difficult circumstances of COVID-19 restrictions, 78% of Muslim prisoners said that their religious beliefs were respected. Faith facilities were welcoming.

The chapel

The multi-faith room

3.53 The chaplaincy had continued to provide good pastoral support during the pandemic. Good use was made of iPads to enable prisoners to view funerals and have contact with dying relatives. A volunteer bereavement counsellor had continued to support bereaved prisoners throughout the pandemic, and another, who had been shielding, had recently returned.

3.54 The team had maintained links to a variety of outside faith support groups and continued to engage in resettlement activity – for example, by its participation in a 'through-the-gate' mentorship scheme.

Health, well-being and social care

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

3.55 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC; see Glossary of terms) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC did not identify any breaches in the regulations.

Strategy, clinical governance and partnerships

3.56 Practice Plus Group Health and Rehabilitation Services Limited ('PPG') was the main health care provider and subcontracted other services, including mental health care, to Barnet, Enfield and Haringey Mental Health NHS Foundation Trust ('BEH').

3.57 Partnership working between the health care providers, the prison and external partners, including NHS England and NHS Improvement, and Public Health England, was strong, particularly in relation to the management of COVID-19, and there had been no positive cases since February 2021. Health care services had implemented recovery plans (see Glossary of terms) in consultation with other stakeholders.

3.58 Health services were well led by a strong management team, including a new head of health care, who had greatly improved communication with staff and stakeholders. PPG was implementing a new model of care, motivated by learning from substantial failures of care highlighted in some of the Prisons and Probation Ombudsman's death in custody reports. There was now a clearer focus on early days, planned and emergency care. The provider had already recruited into several new leadership roles and hoped to implement the new model fully by December 2021.

3.59 Although PPG had suspended its regular audit schedule during the pandemic, this was now restarting. Key audits in relation to medicines management and infection control had continued to help maintain patient safety. Patients with complex needs were reviewed regularly through a strong multidisciplinary approach. The recent recruitment into administrative vacancies would help to improve the range of data available to the service, particularly for governance meetings.

3.60 Incident reporting and management via the Datix electronic reporting system had improved, with incidents now investigated routinely within agreed timescales. Learning from incidents was discussed at local and regional levels and disseminated appropriately.

3.61 Health care services carried several vacancies, particularly in the primary care and substance misuse teams. Strategic recruitment was under way to increase the workforce, with a focus on specialist roles, in line with PPG's new model of care. Well-integrated bank and regular agency staff covered staffing gaps. Most staff we spoke to said that they felt well supported and respected by health care managers. All teams accessed appropriate training and attended regular operational and clinical supervision meetings. A broad range of policies and procedures had recently been reviewed by the head of health care and was readily available for staff.

3.62 Clinic rooms and waiting areas across the site were generally clean and well maintained. Funding had been agreed to refurbish health care treatment areas.

3.63 Well-maintained emergency equipment was available across the prison and was checked regularly. PPG had a dedicated first responder for medical emergencies and employed a bank paramedic while recruiting for a permanent role.

3.64 Most prisoners we spoke to said that access to health care and medicines was reasonable. Health care complaints and concerns were responded to quickly and responses were adequate, but quality assurance was not sufficiently rigorous. Health care complaint forms and boxes in which to submit these were not available on all wings, although prisoners could request forms from the wing treatment room. Only 32% of respondents to our survey said that health care services were very or quite good.

Recommendation

3.65 **Prisoners should be able to access health care complaint forms freely and submit them securely on all wings.**

Promoting health and well-being

3.66 PPG had an organisation-wide approach to health promotion. The service produced a helpful monthly newsletter, based on the national calendar. The newsletter included regular updates about the service and the management of COVID-19, including the vaccination programme.

3.67 A recently recruited nurse had taken the lead on public health issues. The current public health focus was on the rollout of the COVID-19 vaccination programme. This was progressing in line with national guidelines, but the uptake was not as good as the team had wanted, despite ongoing education and encouragement. They had invited members of the community to talk to prisoners about the benefits of the vaccination, to try to increase the uptake.

3.68 Health promotion literature was available in the health care centre and on the wings, and information could be translated, but this was not well advertised. A professional telephone interpreting service was used, and the mental health team booked interpreters routinely for assessments and ward rounds when needed, which was impressive.

3.69 Prisoners had good access to immunisations and screening for sexual health and blood-borne viruses, including treatment for hepatitis C. Barrier protection was available, but not well advertised.

3.70 A range of prevention screening programmes was available, including bowel cancer screening and retinal screening.

Primary care and inpatient services

3.71 All new arrivals received an initial health screen and risk assessment from a nurse, including testing for, and information about, COVID-19, and a GP prescribed any required medication. Although nurses tried to

maintain confidentiality, this was difficult to achieve because of the layout of the reception room and interruptions by officers.

3.72 Completion rates for secondary health screens had improved substantially since the previous inspection. All new arrivals in the last three months had received a comprehensive assessment of their health needs.

3.73 Leadership in primary care had improved. There was now a GP clinical lead, who supported other GPs and the wider team. An additional primary care lead had recently started and a matron had been recruited.

3.74 Prisoners could see a nurse or GP promptly, with regular clinics running across the wings from Monday to Saturday. Waiting times for these clinics were short, although some waiting lists and tasks on SystmOne (the electronic clinical record) needed updating, which PPG took steps to address during the inspection. The health care service was staffed overnight, and appropriate out-of-hours GP support was available.

3.75 A wide range of primary health care and allied health services was available and waiting times were reasonable. Some regular clinics, such as NHS health checks, had paused because of the pandemic. Non-attendance rates for primary care clinics were low.

3.76 The management of patients with long-term health conditions had improved. A bank nurse held a weekly clinic to review patients with an identified need, with GP support to manage more complex needs. A diabetes specialist provided additional support every weekend. Although there was improved use of care plans and oversight of patient registers via a national outcomes tool, further work was needed to enhance support for some patient groups and make sure that care plans were personalised sufficiently.

3.77 There were effective clinical and administrative processes to monitor hospital appointments. Fewer hospital appointments were being cancelled by the prison than at the time of the previous inspection. During the pandemic, the service had used more remote services to facilitate consultations and improved links with local specialists.

3.78 Prisoners being released were reviewed by a nurse and received a summary of their care, information about onward support, and 28 days' supply of any prescribed medication.

3.79 An operational policy outlined agreed admission and discharge criteria for the 17-bed inpatient unit, comprising 12 beds for patients with complex mental health needs and five beds for those with physical or social care needs. There was a good standard of care and multidisciplinary support for all patients on the unit from the health care providers and the prison. The psychiatrist led a weekly ward round, which was well managed. The lead GP provided regular physical health input, particularly for older patients. Some patients with physical health

needs said that they struggled with the noise from those with mental health needs. Funding had been agreed to make improvements to the environment.

Recommendations

3.80 **New arrivals should receive a health consultation in private.**

3.81 **Care plans for prisoners with long-term health conditions should be personalised, fully to reflect their wishes and needs.**

Social care

3.82 Established links between the prison, health care services and Hammersmith and Fulham Council were supported by a memorandum of understanding. Prisoners identified with possible social care needs were referred promptly for assessment. However, timely assessments did not take place as the local authority had not visited the prison to complete an assessment for over a year.

3.83 There was no process for prisoners to self-refer for a social care assessment. There was also a lack of information around the prison to raise awareness about social care, but PPG took steps to address this gap during the inspection.

3.84 One prisoner had a social care package (see Glossary of terms), with an agreed personalised care plan and all needs met by a dedicated and compassionate health care team. However, oversight of record-keeping was insufficient. Currently, there was no social care peer support system operating because of the pandemic.

3.85 A range of specialist equipment was provided to help promote independence and enable safe care and treatment. It was often supplied by the prison because of the lack of local authority assessments taking place.

3.86 Staff made sure that care packages were continued on transfer within the prison estate or release into the community.

Recommendation

3.87 **Prisoners should receive prompt assessment by the local authority following a social care referral. This should be monitored by the partnership board.**

Mental health care

3.88 BEH was the main provider of mental health services, supported by other teams, including primary mental health practitioners from PPG. They offered a comprehensive range of mental health services and had provided face-to-face support to patients during the pandemic. Weekly welfare checks were completed for the most vulnerable and self-help guidance and distraction packs were available. The response to urgent need was prioritised, but routine appointments took place outside of

agreed timescales because of the large increase in referrals (from around 30 to 60 per week over the last year) and there were waits of up to four weeks, which was too long.

3.89 There was a single point of referral, overseen by BEH; this was checked daily to make sure that urgent cases were seen swiftly. Most referrals came from reception and these were prioritised. A joint triage meeting, involving all mental health teams, took place three times a week. Cases were evaluated regularly, with risk zone ratings determining the ongoing input required.

3.90 The multidisciplinary in-reach and therapies team had an impressive skills mix, including experienced mental health nurses, comprehensive psychiatric cover, a team of occupational therapists (OTs) and a speech and language therapist. The psychologist post had been vacant for some time but a new psychologist had now been appointed, although had not yet started. The in-reach caseload was approximately 70 patients with severe and enduring mental health problems, who were managed under the care programme approach.

3.91 The groups offered at the Seacole day centre had been paused as a result of the pandemic, but the content had been delivered on a one-to-one basis by the OTs. Some small groups had restarted on the inpatient unit. The learning disability nurse had recently left, but the OTs worked with patients with neurodiverse needs, offering functional assessments and emotional support, and helped with tasks such as budgeting and cooking.

3.92 The clinical records we reviewed were of a good standard, with clear care plans which were audited regularly by managers.

3.93 Atrium ran counselling services and had recently increased its provision to three counsellors. An improving access to psychological therapies practitioner from the Forward Trust supported 20 individuals with mild to moderate psychological problems such as anxiety and sleep management.

3.94 Mental health awareness training was embedded in the prison officer entry-level training induction, and ongoing sessions had been in place. COVID-19 restrictions had curtailed the latter, but the team planned to restart them when possible.

3.95 Since June 2020, 67 referrals had been made to external hospitals for transfer under the Mental Health Act. In most cases, there had been excessive waiting times to access a bed, despite escalation by the team to NHS England and discussions with local providers.

3.96 The team liaised with community mental health teams before a prisoner's release and then undertook a follow-up call with them or the GP to see how the individual was progressing.

Recommendation

3.97 **Patients requiring admission to hospital under the Mental Health Act should be transferred within current Department of Health guidelines.** (Repeated recommendation 2.75)

Substance use treatment

3.98 The drug strategy group was pursuing a refreshed and coherent whole-prison approach to tackle substance misuse, with the Forward Trust and PPG providing psychosocial and clinical treatment, respectively, for prisoners with drug or alcohol problems.

3.99 Effective screening enabled prompt diversion to the Conibeere unit for newly arrived prisoners experiencing acute drug or alcohol withdrawal. They received close physical monitoring and clinical interventions to make sure that they were stabilised. We observed experienced nurses engaging well with prisoners and delivering a good clinical service. However, there were high levels of staff vacancies and an over-reliance on locum staff, which could have compromised service continuity, although we were given assurances that contingencies for absence cover were in place.

3.100 The Forward Trust was well led and had good staffing levels. They had maintained a presence on-site throughout the pandemic and currently supported 311 prisoners. They saw all new prisoners, notifying them about the service and giving them harm minimisation advice. Although the range of provision had been curtailed and groups were on hold, core psychosocial input had been largely maintained through in-cell packs and one-to-one support delivering structured interventions. There was an open referral system, which included prisoners found to be under the influence of illicit substances. Most prisoners described being well supported and peer support networks had been maintained, although access to peers was more limited.

3.101 Many prisoners needing support were housed on the drug recovery unit on C wing, where Forward Trust staff were located, although services were delivered across the prison. In addition, landing 4 on D wing provided an incentive-based drug-free unit. Working relationships between the Forward Trust and PPG were good, and joint reviews of the current caseload of 180 prisoners in receipt of opiate substitution treatment took place at appropriate milestones. Clinical prescribing was flexible, individually tailored and consistent with prescribing guidelines. Controlled drug administration was well supervised by officers and offered a degree of privacy.

3.102 Individualised discharge planning and support were provided, with overdose training and a supply of naloxone (an opiate reversal agent) provided where appropriate. Links were made with community providers and arrangements to maintain treatment post-release were delivered consistently.

Medicines optimisation and pharmacy services

3.103 Overall, pharmacy services were well managed, despite staffing being stretched at times. Medicines were supplied by an in-house pharmacy in a timely manner. Not-in-possession medicines were supplied mainly on a named-patient basis. The amount of stock medicine had increased because of concerns about potential difficulties in getting medication during the pandemic, but there were plans to return to named-patient medicine supply.

3.104 In-possession risk assessments were undertaken appropriately. However, a large number of patients received only seven days of in-possession medicines, rather than the usual 28 days, without a clear explanation. This put extra pressure on the pharmacy team. In-possession medicines were supplied in clear plastic bags, which were not suitable and did not comply with GPhC standards; this needed to be rectified. Not all cells had lockable storage facilities for in-possession medicines. Prisoners ordered their own in-possession medicines. The pharmacy provided prisoners with a booklet explaining clearly how medicines were managed in the prison.

3.105 Medicines were administered from the wings by pharmacy technicians and nurses twice a day. PPG had taken steps to make sure that medicines administration had been safe during the pandemic. Pharmacy technicians gave prisoners advice about their medicines. Staff took appropriate action for patients who missed medicine doses. Medicine hatches opened directly onto the wings. Officer supervision for the administration of controlled drugs on the substance misuse unit was good, but at the hatches on the wings was inconsistent, which meant that confidentiality was not maintained and there was an increased likelihood of diversion.

3.106 Prescribing and administration were recorded on SystmOne. A pharmacist reviewed all medicines to ensure compliance with the formulary and carried out medicines use reviews on targeted prisoners. Another pharmacist was also now located on the first night centre, to focus on newly arrived prisoners. This had led to earlier identification of prisoners with complex needs and helped to address any discrepancies with medication.

3.107 Medicines could be supplied without the need to see a doctor, through the minor ailments policy and patient group directions, although staff indicated that these were not used to their full potential. There was adequate provision for the supply of medicines out of hours.

3.108 The pharmacy was well organised and there was generally good management of medicines in the treatment rooms across the prison. However, there were no reconciliation procedures on the wings for stock or minor ailments medication.

3.109 Written procedures and protocols were in place. There were well-attended monthly medicines and therapeutics meetings. The prescribing of abusable and high-cost medicines was monitored.

Recommendation

3.110 **Prison officers should fully supervise all medicine administration to ensure patient confidentiality and reduce the risk of diversion.** (Repeated recommendation 2.87)

Dental services and oral health

3.111 Time for Teeth provided eight dental sessions per week, covered by two dentists and a dental nurse. Emergency dental care had been available throughout the pandemic, including pain relief and antibiotics when needed. The dental team triaged referrals on a risk-assessed basis, prioritising treatment based on clinical need. At the time of the inspection, there were about 120 patients on the waiting list, and the wait for routine treatment was between eight and 28 weeks.

3.112 Dental staff completed tooth extractions and other non-aerosol-generating procedures, but were frustrated that they had only recently been allowed to undertake a few aerosol-generating procedures. This was because of delays with the regime recovery plan being agreed, despite officers having received the required training and the necessary equipment being available.

3.113 Advice on oral hygiene was given routinely and disease prevention was promoted. The service had high-quality assurance processes.

3.114 The dental suite met current infection control standards and was suitably equipped, with a separate decontamination room. Dental equipment was maintained and serviced regularly.

Section 4 Purposeful activity

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

Time out of cell

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

4.1 Around 300 prisoners were engaged in some form of activity, most of which was full time. Prisoners who were not working received one hour out of cell each day for outdoor exercise, association and showers, which was inadequate, although this regime was being delivered consistently across all wings. In our survey, 67% of respondents said that they usually spent less than two hours out of their cell on a typical weekday. In our roll checks, 50% of prisoners were locked up during main work periods, which was a larger proportion than at the last inspection. Despite the restrictions, 59% of respondents said that they could go outside for exercise more than five times a week, which was an improvement since the last inspection. Some prisoners who were in full-time work off the wings, such as laundry and kitchen workers, were not given association or exercise time routinely on their return from work.

4.2 Leaders told us that they were taking a cautious approach to improving the inadequate regime, partly because of staff inexperience (see paragraph 3.2). However, time out cell could have been improved with current staff numbers and experience, even in the context of the pandemic. There was no clear roadmap to recovery, with milestones communicated to prisoners and staff, to demonstrate that appropriate priority was being given to this serious concern (see key concern and recommendation 1.42).

4.3 The library was run by the London Borough of Hammersmith and Fulham library service, and had a wide range of books, including audiobooks, easy readers and books in foreign languages. The librarians had returned to the prison in August 2020, but the library remained closed to prisoners and was operating an application and delivery service. Only 25% of prisoners were registered as library users at the time of the inspection, and the number of books being distributed each month was low. In our survey, 21% of respondents said that they were able to have library materials delivered to them once a week. Some wings had small libraries or bookshelves which offered a range of resources, but this was not consistent across the wings.

4.4 The gym had reopened in June 2021. The facilities and equipment were of good quality. At the time of the inspection, the gym was

facilitating four one-hour sessions from Monday to Thursday, and two one-hour sessions on Fridays, for a reduced capacity of 16 prisoners. Outdoor gym sessions had run during the recent lockdown, but had been poorly attended. The prison had recruited new gym staff to relieve staffing shortages, but many of these were still in training, so sessions were sometimes cancelled because of insufficient staff capacity.

4.5 Gym staff had focused on inducting new prisoners, but this had meant that not all prisoners had been offered the opportunity to use the gym since it had reopened. In our survey, just 3% of prisoners said that they could access the gym twice a week.

Recommendation

4.6 **Prisoners should be able to visit the library in person, with suitable social distancing.**

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.

4.7 On 17 March 2020, all Ofsted routine inspections were suspended due to the COVID-19 (coronavirus) pandemic. As part of our phased return to routine inspections of education, skills and work activities in prisons and young offender institutions, Ofsted is carrying out progress monitoring visits. The visit was conducted alongside HM Inspectorate of Prisons. The visit was conducted on site. At the time of the visit, the establishment was at stage 3 of Her Majesty's Prison and Probation Service's (HMPPS) recovery roadmap and had been at that stage for two weeks.

4.8 Progress monitoring visits aim to inform prisoners, employers and government on how establishments are meeting the education and skills needs of all prisoners during this period and how leaders are planning to reinstate a full education, skills and work curriculum. The focus of these visits is on the theme set out below. A progress judgement is made against the theme. That progress judgement will be one of the following: insufficient, reasonable or significant progress.

4.9 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.

4.10 Leaders had made sure that prisoners had access to in-cell education during the national restrictions via a variety of learning packs. Prisoners enrolled on courses such as English, mathematics, customer services and barista training. They were also able to complete some accredited courses in health and safety, food safety and construction. Essential workshops remained open, allowing some prisoners to remain in work.

4.11 Leaders and managers had started planning for the next stage in the regime recovery. They had put together sensible plans to move forward, and these were incremental and in clear steps. They had considered appropriate points in the plan to increase the capacity in workshops and reintroduce all education. Leaders and managers had considered how they would check the knowledge that prisoners had retained on their return to classroom and practical learning. However, they had not planned early enough their return to face-to-face learning on the accommodation units. Consequently, when the restrictions had been lifted recently by HMPPS, prisoners had not been able to benefit immediately from this and continued only to access education remotely in their cells.

4.12 Leaders and managers did not complete robust and thorough quality assurance activities or have sufficient oversight of the quality of the information, advice and guidance that prisoners received. They did not scrutinise the impact of learner support plans or the quality of the remote in-cell learning packs. As a result, they did not identify the improvements needed in these areas.

4.13 Prisoners did not receive effective advice and guidance to help them make informed choices about the most suitable education, skills and work activity to engage in while at the prison. Staff visited prisoners on the accommodation units to discuss their prior knowledge and skills, and create learning plans. However, too many prisoners did not know what courses were available to them or how to access these, or how the results of prior assessments informed their learning journey. Too many prisoners felt unsupported and uninformed about the options available to them in education.

4.14 Prison staff had access to labour market information and used this to produce, for example, a newsletter with information about jobs, details of the careers advice available to prisoners on release, and information about interview skills for those leaving the prison. However, prisoners told us that they were unaware of the employment opportunities available to them on release.

4.15 The information given to prisoners on how to complete their prior knowledge assessments in English and mathematics remotely, in their cells, was not clear enough. As a result, a few prisoners did not complete these fully or accurately. Tutors did not use the results of these assessments effectively to inform learning support plans. Consequently, support for prisoners with additional learning difficulties and/or disabilities was not sufficiently individualised to meet their needs.

4.16 Leaders had successfully implemented their plans to offer a small number of prisoners the opportunity to gain accredited qualifications in hospitality and catering. The newly opened and well-resourced restaurant helped them gain skills in the kitchen and front of house. Leaders recognised the need to increase further the opportunities for prisoners to complete more accredited courses.

4.17 Prisoners who completed the in-cell learning packs in English found them useful. They recognised the knowledge they had gained, such as how to connect words and construct sentences. The biohazard course was well sequenced, helping learners to build their knowledge in a logical way.

4.18 Too often, tutors allowed prisoners to move on to further learning packs without fully completing the assessment activities in the previous one or correcting their mistakes. A few learning packs were poorly presented and contained grammatical errors. A minority of prisoners who completed the health and safety learning pack said that they did not understand the assessment questions and had not received information to help them answer these questions during their learning time.

4.19 The rail track safety materials produced by an external partner were of a good standard. Each module helped prisoners build their theoretical knowledge, which enabled them to understand safe working practices. Tutor feedback was constructive and clearly identified the areas for development. However, the quality of written feedback to prisoners across a variety of learning packs was not consistently helpful and did not support them to improve their work.

Recommendations

4.20 **Leaders should implement their recovery plans quickly, within the parameters of HMPPS restrictions, to enable prisoners to access and benefit from face-to-face education and training.**

4.21 **Leaders and managers should improve the effectiveness of their quality assurance activities, to make sure that they identify areas for improvement in education, skills and work. They should put in place clear improvement actions and challenge their providers robustly to make the necessary improvements.**

4.22 **Leaders and managers should make sure that all prisoners receive effective initial and ongoing advice and guidance to inform them of the opportunities available to them during their time in prison and on release.**

4.23 **Leaders, managers and staff should immediately review how they support prisoners to undertake the assessments of their existing English and mathematics skills. They should make sure that prisoners understand the purpose of these assessments, how to complete them and how the assessments inform their learning and individualised support plans.**

4.24 **Tutors should make sure that prisoners complete their learning and assessment in their learning packs. They should give them clear feedback on how to improve their work over time and correct their mistakes.**

Section 5 Rehabilitation and release planning

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

Children and families and contact with the outside world

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

5.1 The prison had resumed social visits in the week before the inspection. Following the relaxation of national restrictions, prisoners were now allowed to have physical contact with children under the age of 11 and the remaining restrictions were managed sensitively.

5.2 All visitors we spoke to said that staff treated them with respect. Prisoners still wore yellow bibs during visits, which was not proportionate to risk, particularly as prisoners and visitors could now be identified through fingerprint scanners. Visitors and prisoners alike could go to the toilet and then resume their visit. We were told that the national booking centre no longer cancelled visits without informing visitors.

5.3 Family visits and the children's homework club remained suspended. Prison Advice and Care Trust (PACT) children's workers sent out activity packs to children and had resumed activities with children in the visitors centre.

5.4 The visits hall had been refurbished during the pandemic and, together with the visitors centre, provided very good facilities.

The visits hall

5.5 The prison had been quick to introduce secure video calls (see Glossary of terms) in July 2020. Take-up was relatively good, but many 'visits' – over 250 in the three months to the end of May 2021 – had been cancelled because of staffing shortages.

5.6 PACT provided good support for visitors, with appropriate attention to those visiting for the first time. Together with the prison, it had worked hard to mitigate the impact of COVID-19 restrictions. Its family engagement worker had continued to carry a substantial active caseload.

5.7 The wide range of relationship and parenting courses provided before the pandemic remained suspended, but prisoners had been provided with some useful in-cell learning materials. PACT's helpline was well used by prisoners' families. Making it Up, a project to help fathers to write and design a book for their children, was well used. A number of projects with outside support – for example, from Queens Park Rangers football club – were about to be resumed. Some good plans for developing provision had been suspended, although funding for these had been retained.

5.8 Prisoners appreciated access to in-cell telephones, which mitigated the suspension of social visits. In our survey, 93% of respondents said that they were able to use the telephone every day if they had credit. Prisoners could receive correspondence under the email-a-prisoner scheme, which was very well used.

Reducing risk, rehabilitation and progression

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

5.9 A well-designed needs analysis in December 2020, led by the London Prisons Group, had generated a renewed strategy and action plan which were being used to direct improvements in work to reduce the risk of reoffending. Regular reducing reoffending meetings had been restarted in March, drawing together the diverse resettlement pathways. Good partnership working was well established in resettlement, within the prison and 'through the gate'. In practice, however, progress was currently limited because of staff absences due to COVID-19, and the imminent reorganisation of resettlement services delivered by the community rehabilitation company (CRC). This was creating much uncertainty at the time of the inspection; the nature of the new jobs was unclear and the CRC staff had been told that they would be working in the community as an in-reach group rather than in the prison, which many of them felt would be less effective.

5.10 There were management staffing pressures in the offender management unit (OMU). The head of public protection post was vacant, as was a 0.5 full-time-equivalent senior probation officer post. Some support had been given by other establishments, to make sure, for example, that offender assessment system (OASys) assessments and reviews could be countersigned, but this was not an adequate substitute for on-site staff. Progress in offender management work was held up by a gap in positive day-to-day leadership to maintain coordination and morale among the staff. This gap could not be filled by senior managers, despite their best efforts. There was also insufficient drive towards integrating the work across the OMU in line with the Offender Management in Custody model (see Glossary of terms), so that there could be a strong teamwork culture. Several OMU staff felt that their role was not valued by the establishment as a whole (see key concern and recommendation 1.43).

5.11 In our survey, only 10% of respondents said that they currently had a custody plan. The backlog of OASys assessments had been reduced and had recently been consistently below 25. However, in a quarter of the cases we examined in detail, the OASys assessment was not up to date and this overdue sample was, on average, four months late, and one was 30 months late. We came across cases where prisoners who had been recalled more than a year ago had not had their sentence plan revisited during the recall period. Over half of the sentence plans in our sample of 20 were below the standard required.

5.12 Overall, while we saw a considerable amount of solid and competent work in offender management, this did not extend to the majority of prisoners. Too many prisoners had been marking time, with inadequate

contact to support positive outcomes (see key concern and recommendation 1.43).

5.13 The frequency of contact between prisoners and their prison offender manager (POM) had declined since the last inspection and was insufficient, although there were more contacts around key events such as parole and recategorisation, which were of a good standard and well recorded. Most prisoners we spoke to said that it was difficult to contact the OMU, and the opportunity to telephone prisoners in their cells was not taken often enough. The addition of two telephone lines in the OMU, in November 2020, had improved the possibilities for contacting prisoners, but POMs did not seem to be making widespread use of this facility. They told us that it would be useful to have interview rooms available to them on the wings.

5.14 Absence through COVID-19 had affected the OMU badly. Some staff had had to work from home for a long period, and direct contact with prisoners was not then possible, especially as video link was not easily available and the only practical means of communication was for the prisoner to call the mobile phone of their POM, at their own expense in the case of probation staff. The four POMs who were operational prison staff had been redeployed to other duties for over 100 working hours each month, but caseloads were of a manageable size, averaging 26.

5.15 Risk management plans were almost always in place when required. Half of those we examined had been completed to a good standard, and showed good communication between offender managers in prison and the community; several of the others were outdated and not relevant to the current context, or omitted key considerations such as an identified mental health issue.

5.16 Home detention curfew (HDC) processes were adequate, with active efforts by staff to progress cases and with appropriate decision-making. However, in the last six months, 40% of HDC releases had come after the eligibility date, with the average time over target being over seven days. This was often through factors beyond the establishment's control; for example, many prisoners were sentenced with very little time left before release. Some delays were due to waits for address checks or delays in sourcing Bail Accommodation and Support Service accommodation.

Recommendation

5.17 **Prison offender manager contact with prisoners should be regular and meaningful.** (Repeated recommendation S51)

Public protection

5.18 The public protection team was under pressure because of gaps in staffing, but the remaining small team was experienced and committed, and the necessary work was completed on time. The number of prisoners subject to telephone monitoring was kept realistic through a tight focus on risk, and call surveillance did not fall more than a day or

two behind. For the highest-risk offenders, there was good communication between the prison and the community.

5.19 Pressures in courts due to COVID-19 were having an impact on the timeliness of information provision to the prison; for example, many of the temporary warrants received did not give sufficiently detailed information to inform public protection measures, especially in relation to victims.

5.20 There was good coordination with the police, especially in relation to those convicted of violent or sexual offences, with the minimum data set being completed for all the 120 prisoners currently on the violent and sexual offenders register.

5.21 The interdepartmental risk management meeting had been overhauled and now considered all forthcoming high-risk releases in detail. Attendance from key departments was reasonable. Multi-agency public protection arrangements (MAPPA) processes were carried out on time and to a good standard by probation staff, and participation in level 2 MAPPA conferences had increased in the last year through virtual attendance. Our case analysis sample consistently showed active engagement between prison and community offender management staff to identify MAPPA levels and describe risks, and plans to manage any identified risks. A new escalation process had been introduced to make sure that MAPPA levels, determining the level of coordinated support and supervision after release, were set in time.

Recommendation

5.22 **The prison should work with the courts which it serves, to make sure that it receives critical information promptly.**

Categorisation and transfers

5.23 There had been delays in categorisation processes, but progress had recently been made in reducing the backlog. A new electronic system for prompting and tracking categorisation processes had been introduced in February 2021 and was working well to date.

5.24 Progression was good, on the whole, and transfer to training prisons for specific programmes, which had faltered during the COVID-19 restrictions, had picked up again. However, those given category D status often had to wait several months for a transfer to open conditions, despite places being available. Four prisoners were in this position at the time of the inspection.

5.25 Parole processes were prioritised and carried out efficiently. Prisoners serving indeterminate sentences told us that their needs were not being well served, and monthly forums for this group had recently restarted.

Recommendation

5.26 **Prisoners judged suitable for open conditions should be moved to the category D estate without undue delay.**

Interventions

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

5.27 There were no accredited programmes to reduce the risk of reoffending. The recent needs analysis drew attention to the need to address offending behaviour, especially for the substantial number of younger adults, many of whom may not have had the opportunity or sufficient time remaining in their sentence to be transferred to a category C training establishment.

5.28 The psychology team had been working mainly from outside the prison, although often with one staff member in the prison on a rota basis; their numbers had been depleted and only one part-time psychologist remained in post at the time of the inspection.

5.29 Some short resettlement courses had been delivered in-cell throughout the COVID-19 period by CRC staff, who went to the wings to support prisoners in completing them. In our case sample, there was good evidence of in-cell work being provided on varied topics, such as finance, victims, disclosure and thinking skills; this generally was limited to, and driven by, prisoners who were keen to demonstrate progress. Citizens Advice had also continued to give support on benefits and debt issues.

5.30 Bank accounts were opened for a substantial number of prisoners being released. The CRC was active in helping prisoners address outstanding fines and there was good partnership working with the London Collection and Compliance Centre. Prison leaders had played a major role in a pilot project to provide confirmation of identity for prisoners who needed it, thereby helping them to access accommodation, benefits and other community services.

5.31 A custodial manager did valuable work in supporting a small number of veterans. He had compiled a full list of relevant organisations, with their contact details, and made them available in reception. He worked with the armed forces charity, SSAFA (Soldiers, Sailors, Airmen and Families Association), whose worker also came into the prison. Monthly visits by Chelsea Pensioners had been suspended temporarily during the pandemic.

Recommendation

5.32 **Interventions to reduce the risk of reoffending should be available to younger prisoners.**

5.33 **Interventions to reduce the risk of reoffending should be available to prisoners who are likely to spend their whole sentence at HMP Wormwood Scrubs.**

Release planning

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

5.34 In our case sample of those approaching release, there was almost always a resettlement plan, arising from the basic custody screening process carried out by the CRC. Timely engagement by CRC staff had triggered input from other workers, so that the pre-release group received much better levels of contact than those earlier in their sentence. CRC staff were unsure whether future contractual arrangements would facilitate sufficient daily access to prisoners (see paragraph 5.9).

5.35 In our survey, 67% of those expecting release within three months named accommodation as an area where they needed help before release, more than any other area of life. St Mungo's staff worked hard to find housing for as many prisoners as possible. However, over the last 12 months an average of only 61% of prisoners released had gone to permanent or settled accommodation, although very few had had nowhere to go on their first night. A weekly multidisciplinary conference call on imminent releases had helped to improve accommodation outcomes on release.

5.36 The contract for housing support was due to end shortly after the inspection, and it was a concern that the new contract was planned to provide only for sentenced prisoners, and not the large remand population. Much work had been done to help newly arrived prisoners in maintaining tenancies, and it was important that this should continue.

5.37 Few prisoners were transferred to the establishment at the end of sentence for local release, with only three in the previous six months. There were some problems with timely release, and during our visit at least three prisoners were released late. Basic items such as clothing and holdalls were available in reception for those being released, and there were some opportunities for more vulnerable prisoners to be helped by a CRC support worker immediately on release.

Recommendation

5.38 **Leaders should ensure that effective housing support remains in place for all prisoners, including those on remand.**

Section 6 Recommendations in this report

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

Key concerns and recommendations

6.1 Key concern (1.37): While initial assessments by health care staff had improved, the brief risk screening from reception staff was not followed up with an in-depth interview in the first night centre or reverse cohort unit to identify and address immediate needs and concerns. This was concerning, given that the PPO had been critical of the early days risk assessments preceding three self-inflicted deaths.

Key recommendation: All new arrivals should have an in-depth first night interview that covers all risk factors, including self-harming behaviour. (To the governor)

6.2 Key concern (1.38): Too much use of force paperwork was outstanding and both paperwork and available video footage suggested little evidence of de-escalation. Body-worn cameras were not routinely turned on during incidents, and recordings of unplanned incidents were not retained.

Key recommendation: Prison leaders should ensure rigorous oversight and accountability in relation to the use of force, including through routine use of body-worn cameras and thorough completion of paperwork. (To the governor)

6.3 Key concern (1.39): Many staff were inexperienced, had not worked in the prison outside of COVID-19 restrictions and were not confident in handling challenging behaviour. There was a large backlog in training.

Key recommendation: Prison leaders should ensure that staff understand the needs of the prisoners they are supporting, and have the knowledge, skills and support to do this effectively. (To the governor)

6.4 Key concern (1.40): Too many cells designed for one were still being shared by two prisoners. This longstanding problem had persisted despite prison leaders' efforts to obtain approval from HMPPS to convert them to single accommodation.

Key recommendation: Two prisoners should not be held in cells designed for one person. (To the governor)

6.5 Key concern (1.41): There was poor identification of prisoners in protected groups, particularly those with disabilities. Insufficient consideration of monitoring data, together with the suspension of consultation, did not provide assurance that need was properly understood. Even when identified, some evidence of consistent

disproportionate treatment was not acted on adequately. For example, there had been no action in response to monitoring data showing disproportionate use of force on, and segregation of, black prisoners.

Key recommendation: Prisoners in protected groups should be identified systematically and consulted regularly. Monitoring data which shows disproportionate findings should be investigated and result in suitable actions where necessary. (To the governor)

6.6 Key concern (1.42): Most prisoners were locked in their cells for 23 hours a day, which had a serious impact on their wellbeing. Leaders were taking a cautious approach to improving the inadequate regime, partly because of staff inexperience, but time out of cell could have been improved with current staff numbers and experience, even in the context of the pandemic. There was a lack of clear planning for regime recovery.

Key recommendation: Prison leaders should set out a roadmap for substantially increasing prisoners' time out of cell and participation in activity, with clear milestones that are understood by prisoners and staff. (To the governor)

6.7 Key concern (1.43): In our survey, only 10% of prisoners said that they had a custody plan, and although there was some good offender management work, it was not consistent and there was not enough contact with prisoners. Some key management posts in the OMU had been vacant for some time and there was a lack of positive day-to-day leadership. Several OMU staff told us that they felt insufficiently supported in their work.

Key recommendation: Day-to-day leadership in the offender management unit should be strengthened and leaders should ensure that the provision of offender management services is comprehensive and consistent. (To the governor)

Recommendations

6.8 Recommendation (2.8): Strip searching on arrival at the prison should be carried out only on the basis of an individual risk assessment and always in a private space. (To the governor)

6.9 Recommendation (2.14): All violent incidents should be reported on the incident management system. (To the governor)

6.10 Recommendation (2.15): Leaders should ensure that the challenge, support and intervention plan process is used effectively for perpetrators of violence, and that formal support is in place for victims. (To the governor)

6.11 Recommendation (2.19): Adverse adjudications data should be acted on to ensure that adjudications are conducted promptly and to a demonstrably high standard. (To the governor)

6.12 Recommendation (2.25): Special accommodation should be used only in the most exceptional circumstances and not punitively. Records of its use should be detailed and include justification. (To the governor)

6.13 Recommendation (2.32): Segregation paperwork should detail fully the reasons for segregation, and the ongoing record should demonstrate regular, meaningful interaction with those segregated. Paperwork should be quality assured by a senior leader. (To the governor)

6.14 Recommendation (2.33): Strip-searching on entry to the segregation unit should be carried out only on the basis of an individual risk assessment and always in a private space. (To the governor)

6.15 Recommendation (2.43): The handcuffing of prisoners on escort should be based on a full risk assessment and be proportionate to the risks posed. (To the governor)

6.16 Recommendation (3.4): Prison leaders should continue to develop the key work strategy, to ensure that each prisoner has regular and high-quality contact with a key worker. (To the governor)

6.17 Recommendation (3.11, repeated recommendation 2.15): Prisoners should be able to access their property promptly following request. (To the governor)

6.18 Recommendation (3.26): The prison should monitor application numbers and response times systematically. (To the governor)

6.19 Recommendation (3.27): The prison should investigate prisoners' lack of confidence in the complaints system and the reasons for the large numbers reporting that they have been prevented from complaining, and act on the findings. (To the governor)

6.20 Recommendation (3.46): Professional interpreters should be used where necessary to support accurate and confidential communication. (To the governor)

6.21 Recommendation (3.47): The Home Office should inform the prison promptly of all immigration detainees assessed to be at risk in detention. (To the Home Office)

6.22 Recommendation (3.48): Immigration detainees should have access to free, independent legal advice surgeries. (To the Home Office)

6.23 Recommendation (3.49): Paid carers should be available to provide additional support to prisoners with disabilities, and they should be subject to appropriate oversight and supervision. (To the governor)

6.24 Recommendation (3.50): Prisoners with specific evacuation needs should have a clear and up-to-date personal emergency evacuation plan, which is known to all wing staff, including those working at night. (To the governor)

6.25 Recommendation (3.65): Prisoners should be able to access health care complaint forms freely and submit them securely on all wings. (To the governor)

6.26 Recommendation (3.80): New arrivals should receive a health consultation in private. (To the governor)

6.27 Recommendation (3.81): Care plans for prisoners with long-term health conditions should be personalised, fully to reflect their wishes and needs. (To the governor)

6.28 Recommendation (3.87): Prisoners should receive prompt assessment by the local authority following a social care referral. This should be monitored by the partnership board. (To the governor)

6.29 Recommendation (3.97, repeated recommendation 2.75): Patients requiring admission to hospital under the Mental Health Act should be transferred within current Department of Health guidelines. (To the governor)

6.30 Recommendation (3.110, repeated recommendation 2.87): Prison officers should fully supervise all medicine administration to ensure patient confidentiality and reduce the risk of diversion. (To the governor)

6.31 Recommendation (4.6): Prisoners should be able to visit the library in person, with suitable social distancing (To the governor)

6.32 Recommendation (4.20): Leaders should implement their recovery plans quickly, within the parameters of HMPPS restrictions, to enable prisoners to access and benefit from face-to-face education and training. (To the governor)

6.33 Recommendation (4.21): Leaders and managers should improve the effectiveness of their quality assurance activities, to make sure that they identify areas for improvement in education, skills and work. They should put in place clear improvement actions and challenge their providers robustly to make the necessary improvements. (To the governor)

6.34 Recommendation (4.22): Leaders and managers should make sure that all prisoners receive effective initial and ongoing advice and guidance to inform them of the opportunities available to them during their time in prison and on release. (To the governor)

6.35 Recommendation (4.23): Leaders, managers and staff should immediately review how they support prisoners to undertake the assessments of their existing English and mathematics skills. They should make sure that prisoners understand the purpose of these assessments, how to complete them and how the assessments inform their learning and individualised support plans. (To the governor)

6.36 Recommendation (4.24): Tutors should make sure that prisoners complete their learning and assessment in their learning packs. They

should give them clear feedback on how to improve their work over time and correct their mistakes. (To the governor)

6.37 Recommendation (5.17, repeated recommendation S51): Prison offender manager contact with prisoners should be regular and meaningful. (To the governor)

6.38 Recommendation (5.22): The prison should work with the courts which it serves, to make sure that it receives critical information promptly. (To the governor and HMPPS)

6.39 Recommendation (5.26): Prisoners judged suitable for open conditions should be moved to the category D estate without undue delay. (To the governor)

6.40 Recommendation (5.32): Interventions to reduce the risk of reoffending should be available to younger prisoners. (To the governor and HMPPS)

6.41 Recommendation (5.33): Interventions to reduce the risk of reoffending should be available to prisoners who are likely to spend their whole sentence at HMP Wormwood Scrubs. (To the governor and HMPPS)

6.42 Recommendation (5.38): Leaders should ensure that effective housing support remains in place for all prisoners, including those on remand. (To the governor and HMPPS)

Section 7 Progress on recommendations from the last full inspection report

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 2019, outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

The prison should challenge and reduce violence, offer greater support for victims and ensure that residential staff use the challenge, support and intervention plan process effectively. (S40)
Not achieved

The mandatory drug testing (MDT) process should be sufficiently resourced to provide assurance that it is a deterrent to the use and supply of drugs. (S41)
Not achieved

There should be an ongoing and strong focus on reducing self-harm and improving support for prisoners in crisis. Outcomes should be reviewed and evaluated and, where necessary, actions should be adapted to ensure maximum impact. (S42)
Partially achieved

Recommendations

New arrivals should only be strip-searched on the basis of an individual risk assessment. (1.8)
Not achieved

The delivery of induction should be effectively monitored to ensure that all new arrivals complete it. (1.9)
Achieved

Managers should review and revise the approach to the incentives and earned privileges scheme, in consultation with prisoners, to ensure that it provides genuine incentives and promotes positive behaviour. (1.17)
Not achieved

Comprehensive data should be collected, analysed and acted on to ensure that adjudications are conducted promptly and to a demonstrably high standard, and only for suitable cases. (1.21)
Partially achieved

Security intelligence meetings should address identified actions, and analyse and monitor the outcomes. (1.38)
Partially achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2019, outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

The prison should ensure that wing staff understand the needs of prisoners they are supporting, and have the knowledge and skills to do this effectively. (S43)
Not achieved

The equality strategy and action plan should set specific priorities and targets to ensure that equality work becomes part of the prison's daily business, and improves outcomes for all minority groups. (S44)
Not achieved

Recommendations

Every prisoner should have regular contact with trained key workers who can support their welfare needs and progression goals. (2.4)
Partially achieved

The painting and refurbishment programme should be completed and managers should ensure that decent living conditions are maintained. (2.12)
Partially achieved

Two prisoners should not be held in cells designed for one person. (2.13)
Not achieved

An electronic cell bell monitoring system should be introduced and used to ensure that staff are responding promptly to cell call bells. (2.14)
Partially achieved

Prisoners should be able to access their property promptly following request. (2.15)
Not achieved (Recommendation repeated, 3.11)

Prisoner complaints about food should be understood and addressed through a range of measures, including regular and effective consultation, later service of lunch (not before 12pm) and dinner (not before 5pm), and adherence to hygiene regulations. (2.22)
Partially achieved

There should be robust tracking to monitor the timeliness of responses to applications. (2.27)
Not achieved

The prison should affirm LGBT identities in practical ways so that all prisoners feel able to speak openly about their sexuality if they so wish. (2.39)
Partially achieved.

All prisoners should receive a comprehensive secondary health assessment within seven days of arriving at the prison. (2.66)
Achieved

Prisoners with long-term health conditions should receive regular reviews, informed by an evidence-based care plan. (2.67)
Partially achieved

Patients requiring admission to hospital under the Mental Health Act should be transferred within current Department of Health guidelines. (2.75)
Not achieved (Recommendation repeated, 3.97)

Prison officers should fully supervise all medicine administration to ensure patient confidentiality and reduce the risk of diversion. (2.87)
Not achieved (Recommendation repeated, 3.110)

Purposeful activity

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

At the last inspection, in 2019, outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

The prison should implement a core daily programme that gives prisoners reasonable access to all important facilities, together with realistic allocation of staff, and should monitor outcomes for prisoners to correct any failings. (S45)
Not achieved

All prisoners should have their learning needs assessed, and be allocated to activities that meet their needs. Managers should further develop their ongoing work to engage all prison areas in improving prisoners' attendance to their allocated activity. Opportunities for the accreditation of prisoners' skills should be introduced in all appropriate areas. Quality improvement processes should be rigorous and make full use of all the data available, including that on prisoners' destinations, to identify strengths and areas for improvement. (S46)
Not inspected at this inspection.

Tutors' planning of learning and assessment should be effective in engaging all prisoners in the class and helping them to learn. Managers should monitor the quality of learning documents to ensure that prisoners are set realistic targets for learning and that these are monitored. In workshop and industry areas, instructors should encourage prisoners to recognise the skills they are developing and see them as progressing towards employability after release. (S47)
Not inspected at this inspection.

Prisoners on all education courses should be able to achieve good pass rates. All workshop areas should replicate, as far as possible, the standards and resources that apply in industry outside the prison. (S48)
Not inspected 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 2019, outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

The strategic management of reducing reoffending work should be effective and focus sufficiently on outcomes for prisoners to drive improvements across the resettlement pathways. (S49)
Partially achieved

All eligible prisoners should have an up-to-date assessment of their risks and needs. (S50)
Not achieved

Prison offender manager contact with prisoners should be regular and meaningful. (S51)
Not achieved (Recommendation repeated, 5.17)

Public protection procedures should ensure that there is a robust risk management plan in place well in advance of the prisoner's release. (S52)
Achieved

Recommendations

Visitors should always be notified if their visit is cancelled. (4.6)
Achieved

Recategorisation reviews should be completed on time. (4.21)
Partially achieved

The transfer of prisoners to other establishments should be prompt and underpinned by a custody plan. (4.22)
Not achieved

The prison should monitor and analyse accommodation outcomes for all prisoners on release to ensure that its accommodation support is adequate for the needs of the population. (4.27)
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 6 lists all recommendations made in the report. Section 7 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

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

Inspection team

This inspection was carried out by:

Charlie Taylor	Chief Inspector
Hindpal Singh Bhui	Team leader
Rebecca Mavin	Inspector
Nadia Syed	Inspector
Tamara Pattinson	Inspector
Deri Hughes-Roberts	Inspector
Martin Kettle	Inspector
Charlotte Betts	Researcher
Amilcar Johnson	Researcher
Joe Simmonds	Researcher
Jed Waghorn	Researcher
Maureen Jamieson	Lead health and social care inspector
Steve Eley	Health and social care inspector
Richard Chapman	Pharmacist
Tim Byrom	Care Quality Commission inspector
Gary Turney	Care Quality Commission inspector
Jane Hughes	Ofsted inspector
Montserrat Perez	Ofsted inspector
Carolyn Brownsea	Ofsted inspector
Martyn Griffiths	Offender management 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.

Community rehabilitation company (CRC)
From May 2015, rehabilitation services, both in custody and after release, were organised through CRCs, responsible for work with medium- and low-risk offenders. The National Probation Service (NPS) maintained responsibility for high- and very high-risk offenders. Following a change in policy, all offender management was brought under the NPS on 28 June 2021.

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

Offender management in custody (OMiC)
The Offender Management in Custody (OMiC) model, being rolled out across the closed male prison estate, entails prison officers undertaking key work sessions with prisoners (implemented during 2018–19) and case management, which established the role of the prison offender manager (POM) from 1

October 2019. On 31 March 2021, a specific OMiC model for male open prisons, which does not include key work, was rolled out.

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

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

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

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

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

Secure video calls
A system commissioned by HM Prison and Probation Service (HMPPS). This system requires users to download an app to their phone or computer. Before a visit can be booked, users must upload valid ID.

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

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

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

Appendix III Further resources

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed copies of 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.

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

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

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