Report on a scrutiny visit to

HMP Hewell

by HM Chief Inspector of Prisons

4 and 11–12 August 2020

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

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

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

Contents

Glossary of terms 4

Introduction 6

Fact page 8

About this visit and report 9

Summary of key findings 11

Section 1. Safety 14

Section 2. Respect 19

Section 3. Purposeful activity 24

Section 4. Rehabilitation and release planning 25

Section 5. Appendices 28

Appendix I: Scrutiny visit team 28

Section 6. Further resources 29

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 on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Certified normal accommodation (CNA) and operational capacity
Baseline CNA is the sum total of all certified accommodation in an establishment except cells in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged cells, cells affected by building works, and cells taken out of use 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. Some prisons also use the CSIP framework to support victims of violence.

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

Exceptional delivery model (EDM)
A suite of EDMs have been published to guide prisons through the construction of local Regime Recovery Management Plans (RRMPs). An EDM is a guide containing the principles that must be incorporated into a local plan for each element of regime delivery.

Key worker scheme
The key worker scheme operates across the closed male estate, with prison officers managing around five to six offenders on a one-to-one basis.

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

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

Protective isolation unit
Unit or area for the temporary isolation of symptomatic prisoners for up to 7 days; to be used if isolation within their current cellular location is deemed inappropriate (see the specific section for further guidance).

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

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

Short scrutiny visit (SSV)
A type of HM Inspectorate of Prisons (HMI Prisons) visit in which up to three similar establishments (for example, young offender institutions or local prisons) are visited. The aim of these visits is not to report on how an establishment meets HMI Prisons' Expectations, as in a regular full inspection, but to give a snapshot of how it is responding to the COVID-19 pandemic and to share any notable positive practice found.

Social/physical distancing
The practice of staying two metres apart from other individuals, recommended by Public Health England as a measure to reduce the transmission of COVID-19.

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

Introduction

This report discusses the findings of our scrutiny visit to HMP Hewell concerning the conditions and treatment of prisoners during the COVID-19 pandemic.

Hewell is a large category B local prison in Worcestershire, holding up to 900 adult male prisoners – 828 at the time of the visit. The prison had a high churn and continued to serve the courts and manage many short-term sentences throughout the national restrictions. At the time of our visit almost a quarter of prisoners had had their licences revoked, some of whom had been recalled for very short periods. This added to the challenges faced by the prison.

Our visit took place almost five months after restrictions had been imposed. At the start of restrictions, the senior team were properly focused on managing the risks associated with COVID-19 and on safeguarding the, often transient and short-term, population. Given the type of prison and the risks it faced, it was to their credit that only nine prisoners had tested positive for the virus and none at all since late April. Attention to social distancing remained a continuing challenge but overall the prison had managed the initial stages of the crisis well and had kept prisoners and staff safe.

In the early stages the prison had appointed a senior manager to lead on COVID-19. This role focused on delivering a communication strategy to both prisoners and staff and was broadly effective in ensuring that both groups understood the reasons for the restrictions and when they were to be eased.

It is difficult to comment on how Hewell was coping with the pressures and constraints imposed by a pandemic without reflecting on our last inspection (in June 2019) when we found that outcomes for prisoners were poor or not sufficiently good across our healthy prison assessments and significant work was required to address our concerns. The prison had started work on addressing our recommendations when the more immediate concerns of dealing with the COVID-19 crisis had understandably interrupted many of their plans.

The prison had secured some funding to improve the conditions of cells and communal areas, and this work had continued since restrictions were imposed. The prison was clean and generally well maintained, although further work was required in some areas. Health care provision, including management of the response to the virus, was good overall.

There were, however, some concerns. Almost a third of prisoners felt unsafe, though the focus of these feelings had changed somewhat to reflect the impact of COVID-19, particularly the lack of consistent attention to social distancing. It was inevitable that violence would reduce when the regime was so significantly curtailed but, despite this, the number of incidents remained comparatively high, particularly against staff. At the time of our visit Hewell could not be considered a safe prison. The structures to identify and address violence and anti-social behaviour were not yet good enough to take appropriate and consistent action where needed, which was concerning.

Key work had stopped for the majority of prisoners. Meaningful contact was difficult with limited time, and most interactions that we observed were purely transactional to meet the basic needs of prisoners. However, in our survey, 70% of prisoners said they felt respected by staff and they told us of positive experiences. In contrast, 41% of prisoners said they had been bullied or victimised by staff and we were told of negative treatment and poor staff culture.

The needs of many prisoners at Hewell were complex and more than two-thirds identified as having mental health concerns. The care for particularly vulnerable prisoners was good but many still felt that they were not supported at their time of need. There were weaknesses in the assessment, care in custody and teamwork (ACCT) process which did not provide an individual package of care for many prisoners. More needed to be done to understand and address these important issues.

The severely curtailed regime at the start of the restrictions was understandable but almost five months had passed and there had been little progress in ensuring that prisoners had sufficient time out of cell or purposeful activity. This contributed to prisoners' frustration and potentially to a deterioration in mental and emotional well-being. Prison leaders at both local and national level should take note of the fact that 70% of the prisoners we surveyed at Hewell reported problems with their mental health. One hour out of cell each day was simply not enough. The situation was often worse for prisoners on the margins, including the small number who were isolating. They could not have a shower regularly and sometimes had to wait for up to 14 days to do so.

The prison was not fully accessible for many prisoners with disabilities, including wheelchair users, who were routinely sent there. We found some prisoners with impaired mobility who had not had time in the fresh air for weeks and who experienced particular difficulty in accessing showers regularly. This was wholly unacceptable.

Efforts had been made to ensure that prisoners could maintain some contact with their families in the absence of visits. The implementation of in-cell telephones had been brought forward to April. These were greatly appreciated by prisoners, although confidentiality and privacy of calls in shared cells could not always be achieved. The reintroduction of visits had been a priority for the prison after nearly five months without any and this was also valued by prisoners. Social distancing from visitors was clearly challenging, but threats to impose closed visits if this was not adhered to were not managed sensitively or in a proportionate fashion. Purple Visits (see Glossary of terms) had started two weeks before our visit but uptake had been slow.

Offender management work was mostly limited to milestone events such as parole and home detention curfew. Prisoners, including those who were suitable for open conditions, were generally unable to make progress with their sentences. Arrangements for public protection were reasonable and targeted prisoners who posed the highest risk. An unintended consequence of access to in-cell telephones had been an unprecedented rise in call volumes, which exposed the fact that there were inadequate resources to monitor calls consistently where it was appropriate to do so. This was concerning. Release planning for the large number of prisoners affected was reasonable in terms of securing housing. Only five prisoners had been released since late March with no accommodation to go to.

A new governor had arrived five weeks before our visit and had made some small changes relatively quickly, including increasing the time out of cell from half an hour to an hour, opening a workshop for a small number of prisoners and introducing an outside exercise session led by PE staff for all prisoners once a week. Yet many workshops remained empty, classroom-based education was still not permitted and only 14% of prisoners were employed. At the time of our visit recovery plans were only slowly being submitted for approval with limited progress in their implementation.

While we are acutely aware of the need to ease restrictions in a safe and measured way, we felt that progress had been too slow and the restrictions in place were no longer proportionate. Additional improvements could be made by the governor but further progress was limited by rigid national procedures which prevented a creative leadership team from implementing credible and safe plans to improve the regime.

The governor was realistic about the significant challenges that lay ahead. He described an optimistic vision for Hewell of delivering a more person-centred, purposeful and rehabilitative regime within the constraints of running a busy local prison The initial stages of the COVID-19 crisis had been managed well, and the challenge now will be to secure, as quickly as possible, a recovery plan that will enable the prison to fulfil its role safely and decently.

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons
August 2020

Fact page

Task of the establishment
Hewell is a category B adult male local prison

Certified normal accommodation and operational capacity (see Glossary of terms)
Prisoners held at the time of this visit: 828
Baseline certified normal capacity: 1,070
In-use certified normal capacity: 998
Operational capacity: 900

Prison status (public or private) and key providers
Public

Physical health provider: Care UK
Mental health provider: Care UK
Substance use treatment provider: Care UK
Prison education framework provider: Novus
Community rehabilitation company (CRC): Staffordshire and West Midlands; Warwickshire and West Mercia
Escort contractor: GeoAmey

Prison group/Department
West Midlands

Brief history
Hewell was opened in June 2008. It consists of a closed category B male site. The open category D Grange resettlement unit, a grade II* listed manor house built in 1894 in the Jacobethan style, was decommissioned in April 2020.

House blocks 1 to 6 on the closed site hold remand (including potential category A), sentenced and vulnerable prisoners.

Short description of residential units
The six house blocks have single and double cells, all with in-cell sanitation.

House blocks 1, 2 A&C spur, 3 B&C spur and 6	-	Convicted and unconvicted prisoners
House block 2 A&C spur 3 C Spur	-	Induction/first night unit
House block 4	-	Prisoners with drug or alcohol issues
House block 5, 2B spur	-	Vulnerable prisoners
Segregation Unit PSO1700	-	Prisoners subject to segregation rules
Inpatients' Unit	-	Prisoners with health care requirements

Name of governor and date in post
Ralph Lubkowski, June 2020

Independent Monitoring Board chair
Rodger Lawrence

Date of last inspection
June 2019

About this visit and report

A1 Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

A2 All visits carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

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

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

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

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

A7 SVs critically assess the pace at which individual prisons re-establish constructive rehabilitative regimes. They examine the necessity and proportionality of measures taken in

response to COVID-19, and the impact they are having on the treatment of and conditions for prisoners during the recovery phase. SVs look at key areas based on a selection of our existing *Expectations*, which were chosen following a further human rights scoping exercise and consultation.

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

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

Summary of key findings

Key concerns and recommendations

S1 Key concerns and recommendations identify the issues of most importance to improving outcomes for prisoners and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of prisoners.

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

S3 **Key concern**: Senior managers were keen to ease lockdown restrictions and move to a more purposeful regime. However, standardised recovery plans were being introduced slowly in accordance with a national roll-out plan and were prescriptive. Some plans limited the governor's ability to use his judgement about what could work well in the prison. The pace of progress was too slow and was detrimental to the progress and well-being of prisoners.

Key recommendation: HMPPS should grant prison governors appropriate autonomy, or otherwise streamline processes, to allow restrictions to be lifted safely, but with greater speed. (To HMPPS)

S4 **Key concern**: About a third of prisoners who responded to our survey felt unsafe. Levels of violence had reduced since national restrictions were imposed but were still of concern. The strategic management of violence was weak. Violence reduction meetings indicated that a good range of data were collated, but there was limited analysis and response. A case management approach to managing perpetrators of violence and supporting victims was ineffective and not sufficiently embedded in the prison. The number of available interventions to address violence and support victims was inadequate.

Key recommendation: A cohesive prison-wide strategy to manage and reduce violence should be implemented. It should be underpinned by effective data collation and analysis and a variety of suitable interventions to manage perpetrators and support victims. (To the governor)

S5 **Key concern**: The management of and care for prisoners at risk of suicide and self-harm were weak. Prisons and Probation Ombudsman recommendations from previous deaths in custody had not been consistently implemented, embedded or reinforced. Many prisoners subject to assessment, care in custody and teamwork (ACCT) processes said they did not feel supported or cared for. The quality of ACCTs varied: records showed that there was often limited multidisciplinary involvement in reviews and a lack of meaningful contact and engagement. Quality assurance processes had yet to lead to significant improvement.

Key recommendation: The approach to managing suicide and self-harm should be improved. This should include the consistent implementation and reinforcement of recommendations made by the Prisons and Probation Ombudsman, robust management of ACCTs to deliver an individual package of care for prisoners at risk, multidisciplinary reviews and a robust and effective quality assurance process. (To the governor)

S6 **Key concern**: The interactions that we observed between staff and prisoners were often transactional and focused on meeting their daily living needs. Key work had ceased when restrictions were imposed and had only been reintroduced for a small number of prisoners. Most prisoners were not receiving regular sessions with their key workers. This lack of meaningful contact, combined with the very limited regime, potentially affected prisoners' well-being.

Key recommendation: Staff should be given time to conduct regular and meaningful key work sessions with prisoners, with a focus on prisoner well-being and the resumption of purposeful rehabilitation work. (To the governor)

S7 **Key concern**: There was no effective strategic oversight of equality work. There were no support services for prisoners with protected characteristics. This was compounded by prisoners being unaware of or unable to access the discrimination incident reporting process.

Key recommendation: Work on equality should be improved to include robust oversight, effective monitoring and action planning to ensure the individual needs of prisoners with protected characteristics are consistently identified and met. (To the governor)

S8 **Key concern**: Treatment and conditions for prisoners with disabilities, particularly those with impaired mobility and wheelchair users, were inadequate. The site was not fully accessible for wheelchair users who did not consistently have full access to the regime, or an environment suitable for their self-care, well-being and rehabilitation. Wheelchair users, particularly on houseblock 6, often went weeks without access to fresh air and those on houseblock 5 could not access showers easily or regularly.

Key recommendation: The prison should ensure that prisoners with disabilities and impaired mobility, particularly wheelchair users, allocated to Hewell have an appropriately accessible environment with full access to the regime. If these adjustments cannot be offered, such prisoners should be accommodated elsewhere. (To the governor)

S9 **Key concern**: Most prisoners spent only an hour out of their cells on a typical day, with very limited access to purposeful or rehabilitative activity and little opportunity to engage with peers or staff. This was having a considerable impact on their mental and emotional well-being. After five months, we expected plans to ease restrictions to be more advanced.

Key recommendation: Time out of cell for prisoners should be increased to enable more purposeful activities and the opportunity to engage with staff and peers. (To the governor)

S10 **Key concern**: Since the introduction of in-cell telephones, the prison estimated that there had been a 650% increase in the volume of calls that prisoners made to the community. There was a backlog of a month of prisoners' telephone calls and two weeks of calls during June that had not yet been listened to. This undermined public protection processes.

Key recommendation: Prisoners who require telephone monitoring should have calls listened to in a timely manner to ensure public protection. (To the governor)

Notable positive practice

S11 We define notable positive practice as innovative practice or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

S12 Inspectors found the following examples of notable positive practice during this visit.

- Prisoners could receive a vaping pack or general grocery pack on the day of their arrival. This provision was replicated seven days later, when some prisoners may still not have been able to make their first full purchase from the prison shop. This was a thoughtful gesture which reduced the need for new arrivals to borrow from other prisoners and potentially get into debt. (Paragraph 1.10)

- The 100% reconciliation of medicines for patients within a target of 72 hours from admission to the prison was a singular achievement in a category B prison with a sizeable transient remand population. It reduced the risks associated with prescribing for patients whose medical history was incomplete. (Paragraph 2.22)

- Since March, prison staff had operated a minibus service for prisoners on the day of release. Symptomatic prisoners were driven directly to their accommodation and others were taken to a nearby train station. Face coverings were provided for those who needed onward travel. This service was well used: in the three days before our visit, 65% of prisoners who were released from Hewell had used this service. (Paragraph 4.20)

Section 1. Safety

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

Leadership and management

1.1 The leadership team had appropriately focused on managing the risks associated with the COVID-19 virus. National directives were followed and cohorting arrangements had been agreed following consultation with health partners. The last of the nine positive cases of the virus among prisoners had occurred in April, reflecting the overall success of managing the virus in a busy local prison, with a transient and often short-term population.

1.2 A senior manager appointed as COVID-19 lead in the early stages had delivered a broadly effective communications strategy. Prisoners and staff were appraised of restrictions and developments, mostly through notices. The information channel on televisions was also used to present relevant information.

1.3 The need to socially distance was reinforced regularly but was not always adhered to. In our surveys, most staff but only 58% of prisoners felt that reasonable steps were being taken to keep prisoners safe from the virus. The lack of consistent attention to social distancing by staff was considered a real threat to the safety of many prisoners we spoke to.

1.4 The project to install in-cell telephones had been fast-tracked at the beginning of the crisis and fully implemented by April. This was appreciated by prisoners and served to ease some of the burden of the restrictions.

1.5 The regime was extremely limited. The new governor had initiated some small but meaningful changes shortly before and during our visit. For the vast majority this included extending time out of cell from 30 minutes to one hour a day, opening a workshop for a small number of prisoners and permitting one exercise session led by PE staff for all prisoners each week. Although these measures were appreciated, they were neither sufficient nor proportionate. The senior team understood the impact of prolonged restrictions and believed they could do more to deliver additional time out of cell and access to purposeful activity safely, yet workshops and classrooms remained empty. The governor lacked the autonomy to develop improvements and was restrained by the bureaucracy surrounding the implementation of exceptional delivery models (EDMs, see Glossary of terms) known as recovery plans (see key concern and recommendation S3).

1.6 Recovery plans had progressed slowly which was a source of frustration among prisoners and managers. Only three EDMs had been submitted by the time of our visit, and only the early days and social visits elements had been approved. Once approval had been received, the prison moved quickly and social visits had restarted on 3 August. Other recovery plans were ready to be implemented but were held back by prescribed timelines and national guidance. The next round of EDMs was not due to be submitted until mid-August with no date specified for their approval.

Arrival and early days

1.7 Early days arrangements were functional. They focused appropriately on health and safety procedures to keep prisoners and staff safe. Personal protective equipment (PPE, see Glossary of terms) was available to staff if needed. All prisoners alighted from escort vehicles one at a time and their temperature was taken on entry into reception. Appropriate signage promoted the need to socially distance and holding rooms had been risk assessed for the number of prisoners who could be located there. The rooms were bare, with little information to occupy new arrivals.

1.8 Prisoners we spoke to were generally positive about the arrival process, but some were critical of spending too long in reception, in some cases up to four hours. Staff confirmed that there were occasionally lengthy waits for health care staff to see prisoners and for medication to be prescribed.

1.9 Most prisoners could make a short phone call in reception to advise someone of their whereabouts. However, this was inconsistent for prisoners subject to public protection measures and depended on the availability of staff to supervise the call. This was a concern, particularly as induction staff told us that it could take up to 10 days for prisoners to get telephone numbers approved.

1.10 Prisoners could request and receive a vaping pack or general grocery pack on the day of their arrival. This opportunity was repeated seven days later, when some prisoners had not been able to make their first full purchase from the prison shop. This was a thoughtful gesture which reduced the need for new arrivals to borrow from other prisoners and potentially get into debt.

1.11 New arrivals were separated from the rest of the population for 14 days in a designated reverse cohort unit (RCU, see Glossary of terms). The number of prisoners received from the courts had increased and a second RCU had been created. Overall processes were appropriate and well managed by staff.

1.12 For the two-week period that prisoners remained on the RCU they were placed in 'social bubbles' of new arrivals received within a 48-hour period. This was unusual, but appropriate consultation had taken place with health care professionals to ensure it was compliant with COVID-19 management requirements.

1.13 New arrivals were located in clean and reasonably equipped cells. Not all prisoners received a face-to-face interview with induction staff on their first night and some prisoners commented on a lack of privacy, potentially inhibiting them from disclosing important or sensitive information. Some induction literature was available in languages other than English, but staff told us that professional interpreting services, such as The Big Word, were rarely used. All newly arrived prisoners received enhanced welfare checks during their first night. The curtailed induction was limited and did not focus on settling prisoners in to Hewell but on the completion of various prisoner compacts.

1.14 Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) had recently returned to their role of supporting new arrivals on the RCU in the evening periods.

1.15 All prisoners on the RCU received access to the same basic regime as the rest of the population (see paragraph 3.3).

Managing behaviour

1.16 In our survey, 31% of prisoners said they felt unsafe (see paragraph 1.3). Twenty-six per cent of prisoners said they had experienced victimisation or bullying from other prisoners and 41% victimisation by staff. This was concerning and needed to be investigated by the prison.

1.17 Since the start of lockdown on 23 March, there had been 100 recorded assaults on staff and prisoners. This represented a reduction of 52% over a similar period before restrictions were imposed but was still comparatively high. There had been a decrease in prisoner on prisoner assaults but those against staff had remained much the same.

1.18 The prison lacked a cohesive strategic framework for managing violence. A good range of collated data were presented at violence reduction meetings, but there was limited analysis or action. For example, despite managers acknowledging the availability of illicit drugs, associated debt and low-level bullying, there was no coherent approach to address and mitigate these issues. A recently introduced multidisciplinary tasking meeting had the potential to be effective but it was too early to assess its impact (see key concern and recommendation S4).

1.19 The prison responded to violence predominantly by using the incentives and earned privileges (IEP) scheme, adjudications and challenge, support and intervention plans (CSIP, see Glossary of terms). However, plans were rudimentary and did not focus on appropriate interventions to reduce an individual's propensity to commit future acts of violence. Victim support was equally inadequate and limited to CSIP as a support mechanism for those who were repeated victims of violence or had an obvious enduring vulnerability. Structures to identify and support self-isolating prisoners were weak (see paragraph 1.31).

1.20 The IEP scheme remained notionally in place. A few prisoners were on basic level at the time of our visit, primarily because of violence or non-compliance such as refusing to share or move cells. It was appropriate that, in accordance with national directives, those on basic retained their televisions. There were no incentives to reach or maintain enhanced status, except for more funds to spend on the weekly prison shop.

1.21 The number of use of force incidents in the past six months had reduced by 14% compared with the same period in 2019, although there was evidence of a recent increase. The initial decrease was predictable given the reduced time out of cell and regime delivered since lockdown, but the recent rise potentially represented increasing prisoner frustration and non-compliance. Governance arrangements were adequate and monthly meetings continued to take place. Overdue documentation was minimal. There were few incidents of baton use and these were reviewed appropriately. There had been no use of PAVA incapacitant spray. The lack of routine scrutiny of CCTV footage was an omission but there was evidence of managers tackling inappropriate use of force, with three investigations commissioned in recent months.

1.22 The segregation unit was clean and bright. Staff were friendly and approachable, and prisoners were positive about their treatment. Segregated prisoners had access to a daily shower, phone call and just 30 minutes of exercise, but there was no in-cell electricity for kettles or televisions. During the previous six months, 18 prisoners on an assessment, care in custody and teamwork (ACCT) document (assessment, care in custody and teamwork case management of prisoners at risk of suicide or self-harm) had been held in segregation. Some of the defensible decision logs that we reviewed lacked sufficient justification for their continued segregation. Since the restricted regime had been introduced, members of the Independent Monitoring Board (IMB) were no longer participating in segregation review meetings.

1.23 The use of adjudications had decreased since the imposition of restrictions but not to the same extent that we have observed elsewhere. Offences consisted primarily of violence, unauthorised items and general non-compliance. The process was well managed and the number of outstanding adjudications was not excessive. Some segregation and adjudication data were collated but, in the absence of recent review meetings, it was unclear how they were used to provide assurance of practices or inform future delivery.

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

1.24 Since the start of the pandemic and lockdown measures, 111 prisoners had been tested for coronavirus, nine of whom had tested positive. At the time of our visit, there were no positive cases. Seventy-nine prisoners were considered clinically at risk and were located on a shielding unit (see Glossary of terms). A small number of symptomatic prisoners and those at risk by association were located on the prison's designated protective isolation unit (PIU, see Glossary of terms). Shielding and symptomatic prisoners were appropriately supported with adequate safeguards in place, although the latter group experienced a particularly restrictive regime (see paragraph 3.4).

1.25 There was a high level of complex need at Hewell. In our survey, 70% of prisoners said that they had problems with their mental health and, while this may not have reflected diagnosed mental illness, it was indicative of prisoners' perceptions of their own mental and emotional well-being.

1.26 The number of recorded self-harm incidents had reduced by 10% following the imposition of regime restrictions. There had, however, been a 35% increase in the number of prisoners committing an act of self-harm in the same period.

1.27 The safer custody team was largely reactive with a reduced staffing complement since lockdown due to redeployment. Regular monthly meetings had continued which was positive. However, good data collation was undermined by a lack of strategic analysis and response. The weekly multidisciplinary safety intervention meeting had continued, but was poorly attended, too few prisoners were discussed and not enough actions were generated. Managers acknowledged these weaknesses.

1.28 We observed some good care, particularly for the most vulnerable, but overall support for those in crisis was not always good enough. Prisoners with the highest level of need were generally identified and given appropriate support. However, many other prisoners described growing frustration and a decline in their mental wellbeing due to the restrictions in place. Some felt that staff did not fully acknowledge their gradual deterioration and that they had to resort to committing an act of self-harm or non-compliance to gain the support they felt they required.

1.29 In our survey, only 34% of prisoners who had been supported through the ACCT process felt cared for by staff. The ACCT documentation that we reviewed varied in quality and generally did not provide evidence of meaningful contact and engagement or consistent multidisciplinary input, including from prisoners' families. Although quality assurance work was now taking place, it had yet to lead to tangible improvements. More work was needed to ensure that an individual package of care for prisoners at risk was provided (see key concern and recommendation S5).

1.30 Prisoners in crisis could contact the Samaritans using in-cell telephones. The formal Listener scheme continued to function but was not effective. There were just four trained Listeners,

all located on the same residential unit, who were not allowed to see prisoners on other wings because of COVID-19 restrictions.

1.31 There was no central oversight or additional support for prisoners who were choosing to self-isolate (mostly due to debt or other issues with prisoners), which was concerning. The prison could not tell us how many prisoners were self-isolating for their own safety and were not aware of some prisoners we spoke to. One prisoner with a history of self-harm who had been self-isolating for a month described inconsistent delivery of the regime and being subjected to abuse by other prisoners, without adequate staff challenge.

1.32 There had been two self-inflicted deaths and four by natural causes since our last inspection. A death in custody action plan, informed by Prisons and Probation Ombudsman (PPO) recommendations, was in place but not all actions had been completed or sufficiently embedded. Some actions had lapsed and a review of the action plan was needed in light of prevailing temporary working arrangements (see key concern and recommendation S5).

Section 2. Respect

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

Staff-prisoner relationships

2.1 In our survey, 70% of prisoners said that most staff treated them with respect. Many prisoners spoke positively to us of their interactions with staff. Some prisoners, however, referred to negative treatment and poor engagement by staff. This was more pronounced on certain house blocks, particularly house block 6.

2.2 Most contact between staff and prisoners concerned their daily living needs and we saw limited positive interactions beyond this. This was reflected in our survey where only 34% of prisoners said that a member of staff had spoken to them in the last week to ask them how they were getting on.

2.3 Following lockdown, key worker sessions had ceased and had only recently been reintroduced for prisoners with greater need such as complex cases or those subject to assessment, care in custody and teamwork (ACCT) processes. The restricted regime (see paragraph 3.2) and the limited keyworker contact made it difficult for productive relationships between staff and prisoners to develop (see key concern and recommendation S6).

Living conditions

2.4 A 'clean and decent' project had been implemented in January 2020, overseen by a senior manager. Despite the pandemic, investment and work on the environment had continued and improvements had been made to living conditions. Most communal areas were well presented and maintained although some areas, such as showers and in-cell flooring, still needed repair. A tiered quality assurance process had been put in place to ensure and maintain better standards.

2.5 Cleaning cupboards had been placed on every wing and in other areas of the prison as part of the project, together with cleaning schedules and job descriptions for cleaners. We saw evidence of regular cleaning and the prison was clean and tidy. However, some prisoners spoke of difficulty in accessing suitable cell cleaning materials, including protective disposable gloves.

2.6 Cells were well equipped with the essentials and privacy for toilet arrangements. Ventilation was limited and conditions were stifling during the very hot days of our visit. The governor had purchased 50 fans which were appreciated by the prisoners who received them.

2.7 The regime allowed most prisoners to shower every day. Others did not always have the opportunity for a daily shower which was unacceptable. This was particularly acute for those isolating on the PIU who could go without a shower for up to 14 days. A number of wheelchair users struggled to shower regularly because there were no accessible facilities (see paragraph 2.13).

Complaints, legal services, prisoner consultation and food and shop

2.8 Consultation with prisoners was developing but needed improvement. Wing forums and prison council meetings offered a platform for consultation. The forums were better established but prison council meetings were only attended by a few prisoners and records of discussions were not disseminated. Most prisoners we talked to were not aware of either forum or actions that arose.

2.9 The number of complaints since lockdown had been consistently high in comparison to other similar prisons. The lack of robust oversight meant that recurring themes, such as property and prison shop orders, were not addressed. There was no quality assurance of the complaints process and we identified complaints that were not responded to in a timely manner. Some prisoners told us that complaints were not always answered.

2.10 The provision of food and canteen had been largely unaffected by the restrictions in place. In our survey, 46% of prisoners said the food was good or reasonably good. A hot meal was served for lunch with a cold meal and a snack pack for dinner. We observed a good range of menu choices and good portion sizes.

Equality, diversity and faith

2.11 There had been no strategic oversight of equality work since the lockdown and for a significant period before that. Equality governance meetings had recently started but full analysis of all relevant data and clear action planning needed development.

2.12 No support was offered to prisoners in protected characteristic groups. This was particularly detrimental to prisoners with disabilities and foreign national prisoners (see key concern and recommendation S7).

2.13 Hewell was not a fully accessible site but prisoners with disabilities were routinely accepted, including those with limited mobility and wheelchair users. Only one house block was fitted with a lift, which was out of order at the time of our visit and had been for some months previously. There were no ramps to facilitate access in the other houseblocks. Some wheelchair users could not go outside each day and others were unable to shower regularly without difficulty. This was unacceptable. After the visit we were advised that the lift had been repaired and a ramp had been ordered to facilitate wheelchair user access to the showers on house block 5. This was positive but continuing oversight was needed to prevent further recurrences (see key concern and recommendation S8).

2.14 No support was offered to foreign national prisoners. No immigration surgeries had been conducted by the Home Office for a significant period and prisoners with potentially complex asylum cases were not offered any support to understand their legal position and actions required of them.

2.15 The discrimination incident reporting process was not well promoted and we were not confident it was used effectively. Many prisoners were not aware of it and forms were not readily available on most of the house blocks for them to report an incident. We identified one complaint with a discriminatory element that had not been alerted for processing through the relevant channels.

2.16 There was some monitoring of prisoners who had contracted the virus. Additional welfare checks had been introduced for higher risk prisoners, such as black and minority ethnic

prisoners with health complications. We were told that there was no evidence that prisoners from protected groups had been more adversely affected than others among those who had tested positive for COVID-19.

2.17 Despite the suspension of corporate worship, the chaplaincy remained active and supportive of prisoners. Alternatives to corporate worship had been implemented. Church services and sermons were broadcast on Wayout TV (an in-cell television communication tool for prisoners). Friday prayers were followed on the radio but at the time of the visit the prison radio was not working.

2.18 The chaplaincy provided one-to-one support for prisoners suffering bereavement. They had enabled virtual attendance at funerals when prisoners were unable to attend and provided pastoral support for the small number who were able to attend in person.

Health care

2.19 There were effective strategic partnership working arrangements between the health services commissioner, providers and prison which met the health needs of the population. Partners had shared operational contingency plans for COVID-19. Service restoration plans and EDMs referred to health and were underpinned by a joint understanding of risks. Public Health England had joined the partnership at pertinent points during the COVID-19 emergency, offering valued support and guidance.

2.20 Care UK services were well led. It was notable that, even during the pandemic, health and social care arrangements had improved, with recommendations under consideration and the completion of improvements required by the health regulator, the Care Quality Commission. Further development had been interrupted by the lockdown.

2.21 Prison and health staff had been made aware of COVID-19 measures: the requirement for social distancing, availability of correct PPE, increased oversight of potential infection risks and provision of separate areas for the PIU, RCU and shielding. We observed social distancing markers on the ground and information posters throughout the prison.

2.22 New arrivals were seen by a registered nurse and screened for illness, including COVID-19. Drug workers were now available in reception and GPs were present to prescribe. In part because prisoners were readily accessible on the RCU, 100% of secondary health assessments were being achieved in the first 72 hours. This was remarkable in a local prison and reduced the risks associated with prescribing for patients whose medical history was incomplete.

2.23 Care UK information on COVID-19 was given to patients and those shielding. Prisoners on the RCU and those with positive test results received health well-being checks. Those shielding received enhanced monitoring as clinically indicated.

2.24 Access to most primary care services had been curtailed during lockdown, but nearly all had been restored by early August. Wing-based triage and treatment by nurses and GPs had been introduced during lockdown, with GPs opting to wear medical 'scrubs' to be more easily identifiable while visiting prisoners in their cells. Health staff were alert to prisoners whose access to external exercise (direct sunlight) was limited and who may benefit from precautionary supplements of vitamin D. The dentist had continued to visit the prison during lockdown and offered triage, prescribing, advice and emergency non-aerosol treatments.

2.25 NHS England, on behalf of partners, had commissioned an external review of wellbeing during lockdown and the fieldwork had just been completed at Hewell. This demonstrated a

recognition of potentially deleterious effects of reduced physical exercise and mental stimulation caused by lockdown.

2.26 The telemedicine unit had been re-sited within health care to enable more patients to consult remotely with hospital specialists. Access to hospital appointments had continued during lockdown, albeit some hospitals had initially restricted access because of COVID-19.

2.27 Some waiting lists had become very extensive during lockdown, including 330 for the dentist waiting up to 21 weeks (although some of the 291 new patients had been triaged and prioritised accordingly); 100 waiting up to 24 weeks to see the optician and 53 up to eight weeks for physiotherapy. Work was in hand to try to reduce the lists, including extra clinics.

2.28 Our survey reflected legitimate frustrations among prisoners that they could not access health care, although their access to primary care nurses, GPs and dental advice during COVID-19 was at least as good as in the community. Lockdown had changed working practices, and prisoners' failure to attend appointments had almost been eliminated. However, this was to emerge again in re-instituted dental clinics, which represented a waste of clinical time.

2.29 The in-patient unit had closed and its future was under review.

2.30 Oversight of social care was good. During 2020 to date, 13 prisoners had been referred for a local authority assessment, resulting in five packages of care. One prisoner was in receipt of social care at the time of our visit with local authority carers entering the prison to provide support. The built environment of the house blocks was not always suitable for those with mobility issues, such as wheelchair users (see paragraph 2.13).

2.31 The Midlands Partnership Mental Health Trust delivered mental health and substance misuse services via the integrated Inclusion team. The 40 co-located staff had been restricted to 17 in the office to reflect social distancing, so that the majority were not able to be on site at the same time. This restricted the delivery of usual services. There were not enough rooms in the prison to deliver high intensity one-to-one therapy, and therapeutic groups had been curtailed because of social distancing restrictions.

2.32 The Inclusion team ensured that all referrals were seen within five days (three days for urgent cases) and prioritised the most vulnerable for continuing monitoring and support. The combined case load of 450 was returning to the usual level following the resumption of receptions. The psychosocial drug workers and clinical prescribers jointly monitored 173 patients in receipt of opiate substitution therapy and the handful receiving alcohol detoxification therapy. There was good use of the care programme approach (mental health services for individuals diagnosed with a mental illness) to manage patients with complex mental disorders.

2.33 An extensive range of relevant in-cell guided work packs were available to prisoners, and new packs were in development. The team planned to telephone prisoners in their cells when the facility became available to them, to provide wellbeing checks and support and enhance monitoring.

2.34 Inclusion had developed a new approach to transferring patients to hospital under the Mental Health Act, which included weekly monitoring with service commissioners and specialist commissioners. This had proved very effective with only two patients awaiting transfer (compared to 16 in April) and waiting times, while still beyond target, reduced.

2.35 Health services had continued to provide pre-release support. They assisted patients to find GPs and provided harm minimisation advice and naloxone to take home, as necessary. Prisoners also received PPE to take home and shielding letters, as required. Public Health

England had been informed of two prisoners who had tested positive for coronavirus before their release to enable continuity of care and monitoring in the community.

Section 3. Purposeful activity

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

3.1 Despite the easing of restrictions nationally, progress to ease restrictions at Hewell had been slow. While it was positive to see some very recent improvements, a lot more progress was needed to make the regime more meaningful and purposeful (see paragraphs 1.5 and 1.6).

3.2 The regime was very limited and lacking in purpose. Until recently, prisoners had only received half an hour out of their cell each day. This included time to shower and exercise in the fresh air, and to use the telephone before in-cell telephones were introduced (see paragraph 4.1).

3.3 At the time of our visit, time out of cell for most prisoners, including those on the RCU, had increased to an hour, which was an improvement but still not adequate. Half an hour was dedicated to outside exercise while the other half afforded the opportunity for domestic activities such as showers and cleaning cells. The potential impact on prisoners' mental and emotional well-being of such extended periods confined to a cell was significant (see key concern and recommendation S9).

3.4 Prisoners located on the protective isolation unit (see Glossary of terms) or those isolating in the general population received even less time out of cell. They only received 30 minutes' exercise and, during their 14-day isolation period, did not have access to showers. Personal hygiene consisted of using sinks in the cells, which was unacceptable.

3.5 Since lockdown, classroom-based learning had ceased and, at the time of our visit, only about 55 prisoners were engaged in in-cell courses. Education staff marked their work and provided feedback. Prisoners had yet to be recruited back into education, although this was under review.

3.6 Only 14% of the population were employed at the time of our visit, the vast majority in domestic roles and essential services such as kitchens and waste management. All industrial workshops had closed at the start of lockdown and the pace of reopening workshops with social distancing measures was slow. Five months after lockdown only one workshop had re-opened with space for just six prisoners. There was capacity to do much more.

3.7 The gym had closed when restrictions were imposed and remained closed. In-cell workout distraction packs were produced and made available to prisoners. During the week of our visit, PE staff had started to deliver outdoor circuit sessions which was positive. The timetable provided scope for the whole population to have one hour a week of activity outside, led by PE staff. This was in addition to the daily exercise period they received on their wings.

3.8 The library had remained closed during the restrictions, and county council library staff were only now returning to the prison to plan future provision as restrictions eased. There was a limited range of books on most wings, which could be replenished by wing staff from an identified stock held in the library. We found that many prisoners were not aware of what was available to them. Prisoners were unable to make requests to loan books or other library material, such as DVDs.

Section 4. Rehabilitation and release planning

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

Contact with children and families

4.1 There was now a reasonable range of initiatives to enable prisoners to maintain contact with family and friends. In-cell telephones had been installed in April and prisoners could access telephones 24 hours a day. They were also given additional phone credit to stay in touch with their families. In our survey, 91% of prisoners said they were able to use the phone every day. However, prisoners told us that it was difficult to make confidential or private calls in shared cells.

4.2 Purple Visits (see Glossary of terms) had been introduced about three weeks before our visit. Prisoners told us that this potentially enabled them to maintain contact with family and friends, especially those who lived at a distance. Bookings for this service had been slower than expected and there had been some connection problems. At the time of our visit, only about one-fifth of prisoners had used a purple visit. More prisoners were starting to book purple visits and the prison hoped to provide each prisoner with a 30-minute session each month.

4.3 Since March, a reply function to the 'email a prisoner' scheme had been introduced so that prisoners could draft responses which were then scanned and returned to the sender via an online portal. Use of this service had increased and the prison received approximately 120 emails a day. Responses were timely and some prisoners appreciated this alternative method of contacting families. Electronic tablets allowed bereaved prisoners remote access to funerals. These were well used and appreciated by prisoners (see paragraph 2.18).

4.4 Social visits had been reintroduced the week before our visit, including at weekends. Seventy-six prisoners had been able to see their family and friends for the first time in five months. Improvements to the environment made it more welcoming for visitors. Processes were well managed and some families we spoke to said that the prison had communicated well with them about the COVID-19 restrictions.

4.5 There was now a ban on physical contact between prisoners and their families and children. During our visit, one prisoner breached restrictions by making physical contact and hugging his child at the start of the visit. The visit continued, but the threat of enforcing three months of closed visits was insensitive and disproportionate in the circumstances. We understand the need to ensure social distancing during visits but the prison should also ensure that any sanctions are imposed only after full consideration of individual circumstances and with appropriate senior manager authorisation.

4.6 Limited one-to-one family support work had been in place for some prisoners since March. This was delivered by a family support worker who helped prisoners to liaise with social workers in the community. At the time of our visit, additional staff from Barnardo's and the YMCA had resumed work at the prison with plans to increase family support work. The prison hoped to restart Storybook Dads (prisoners recording stories to send to their children) and the 'Me n' My Dad' parenting programme in the near future.

Sentence progression and risk management

4.7 Hewell had a high turnover of prisoners and many stayed for a very short time. At the time of our visit, 24% had had their licence revoked (some of whom were recalled for as little as 14 days), 42% were unsentenced and almost one-third of those who were sentenced had been at the prison for less than three months. In our survey, only 44% of prisoners knew what their custody plan objectives or targets were and only 23% of those said that staff were helping them to achieve these.

4.8 Prisoners' contact with prison offender managers (POMs) during the earlier phase of the pandemic had been very limited. The POMs prioritised critical offender management work, for example prisoners with parole hearings and those who required communication with their community offender manager. POMs had recently had some face-to-face contact using rooms on the wings large enough to ensure social distancing. Despite this, levels of contact with prisoners had reduced compared to pre-pandemic levels.

4.9 At the time of our visit, POMs each had about 30 prisoners on their caseload. Probation POMs managed high-risk cases and prison POMs medium- and low-risk cases which was appropriate.

4.10 Prisoners who had been granted category D status were unable to move to open conditions. At the time of our visit, progression had stalled for the 21 prisoners suitable for open conditions. One prisoner expressed frustration at being granted category D status eight months previously but, with release due in two months, would not benefit from progressing to open conditions. Home detention curfew processes were sound but the lack of suitable accommodation in the community prevented or delayed some releases.

4.11 At the time of our visit, most prisoners had an up-to-date assessment of their risk to others and their offending-related needs (OASys). Within the previous 12 months, 85% of prisoners had had a risk assessment and sentence plan completed, which we considered best practice. POMs had used the early stages of the pandemic to work on the backlog of OASys.

4.12 No offending behaviour programmes had been delivered since September 2019. At the time of the visit, all formal one-to-one offending behaviour work had ceased. This had created a significant gap in the process of rehabilitation for some prisoners. Victim empathy packs were available to prisoners to complete in their cells, but many were released without completing interventions to reduce their risks.

4.13 Since the introduction of in-cell telephones, the prison estimated that there had been a 650% increase in the volume of calls that prisoners made to the community. At the time of the visit, 102 prisoners were having their telephone calls monitored. Identification of prisoners who required monitoring was appropriate and reviews were timely. However, despite the allocation of more staff to monitor calls, at the time of our visit there was a backlog of one month. There had also been two weeks of calls during June which the prison had not listened to. This undermined public protection processes (see key concern and recommendation S10).

4.14 The monthly interdepartmental risk management meeting had been suspended from February to June. However, managers maintained oversight of high-risk cases approaching release during this time and ensured that MAPPA levels (multi-agency public protection arrangements) were set for these prisoners in sufficient time before release.

4.15 Information sharing between the prison and the community was reasonable. The prison used teleconferencing to enable three-way discussions between the POM, prisoner and the

community offender manager. Many community offender managers had used the email a prisoner function to contact prisoners during the pandemic.

Release planning

4.16 Release to the community was a frequent occurrence at Hewell and there had been about 170 releases in the last month. In our survey, 54% of prisoners said that they expected to be released within the next three months, but only 23% of those said that someone was helping them to prepare for release.

4.17 Both Staffordshire and West Midlands and Warwickshire and West Mercia community rehabilitation company (CRCs) had been on site during the pandemic. Until recently, they had not provided thorough, face-to-face resettlement support to prisoners before their release. Work had focused primarily on prisoners' accommodation needs and there had been some gaps in the provision, for example for prisoners who had experienced abuse or victimisation. At the time of our visit, face-to-face contact was increasing and resettlement staff had returned to the main house blocks.

4.18 The lack of face-to-face contact had sometimes made verification of resettlement needs 12 weeks before release challenging. The CRCs used the internal mail system to send and receive resettlement plans. Most plans were returned but in some cases where they remained outstanding, resettlement staff relied on prison officers to retrieve them.

4.19 Housing advice and support remained reasonable. Since lockdown, only five prisoners had been released homeless. Approximately 65 prisoners had been referred to the community homelessness prevention team or into short-term transient accommodation. A Citizens' Advice worker had been available remotely for resettlement staff to seek support before release for prisoners with universal credit applications.

4.20 Practical support for prisoners released during the pandemic was reasonable. Since March, prison staff had operated a minibus service for prisoners on the day of release. Symptomatic prisoners were driven directly to their accommodation and others were taken to a nearby train station. Face coverings were provided for those who needed onward travel. This service was well used and in the three days before our visit, 65% of prisoners who were released from Hewell had used it. Some prisoners were issued with a mobile phone on release to enable them to contact families and professionals.

4.21 No prisoners had been released under the end of custody temporary release scheme (ECTR, see Glossary of terms).

Section 5. Appendices

Appendix I: Scrutiny visit team

Kellie Reeve	Team leader
Kam Sarai	Inspector
Rebecca Stanbury	Inspector
Nadia Syed	Inspector
Paul Tarbuck	Health care inspector

Section 6. Further resources

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

Prisoner survey methodology and results

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

Staff survey methodology and results

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