Report on an independent review of progress at

HMP Woodhill

by HM Chief Inspector of Prisons

29–31 July 2024

Contents

Section 1 Chief Inspector's summary

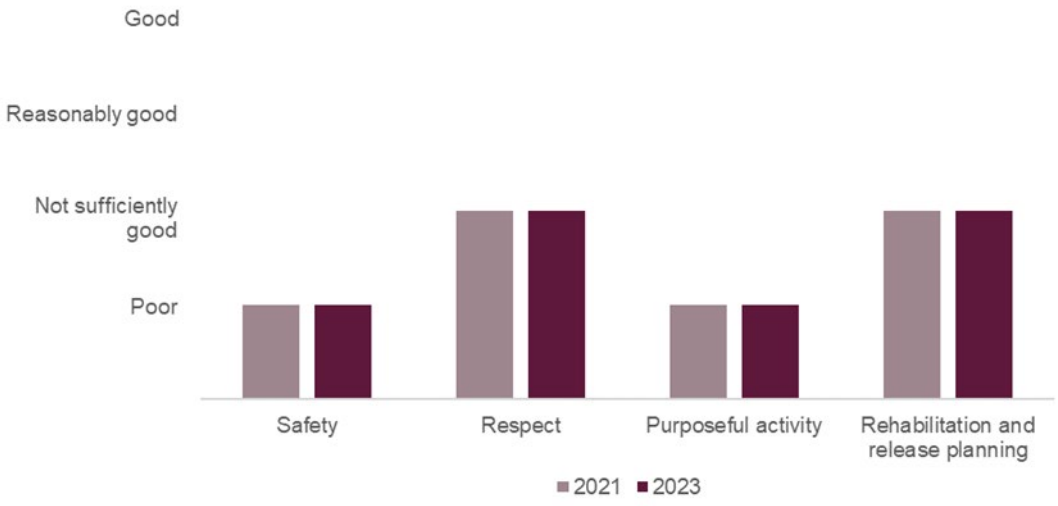
1.1 Opened in the early 1990s and situated in Milton Keynes, HMP Woodhill has several functions: it is a category B trainer, but also holds a small number of category A prisoners, as well as operating as a site for several specialist units and facilities. Although it can hold up 644 adult men when fully operational, the temporary closure of accommodation had reduced the number of prisoners held at the time of our visit to around 350.

1.2 This review visit followed up on the concerns we raised at our last inspection of HMP Woodhill in 2023.

What we found at our last inspection

1.3 At our previous inspections of HMP Woodhill in 2021 and 2023, we made the following judgements about outcomes for prisoners.

Figure 1: HMP Woodhill healthy prison outcomes in 2021 and 2023
Note: rehabilitation and release planning became 'preparation for release' in October 2023.



1.4 Following the last inspection in August 2023, I wrote to the Secretary of State to invoke the Urgent Notification process (see Glossary) for HMP Woodhill. Many prisoners told us that they felt unsafe, and the prison had the highest rate of serious assaults against staff in the country. Reported incidents of violence at the prison had risen sharply, the use of force against prisoners was the highest in the adult male estate and illicit drug use was widespread. The rate of reported self-harm was, again, the highest in the adult male estate, and arrangements to support new arrivals at the prison were not good enough.

1.5 Prisoner frustration, caused by a lack of access to basic amenities and delays in getting anything done, was evident. Emergency cell call bells often went unanswered for long periods and key work (see Glossary) was non-existent. There were many relatively inexperienced staff who lacked confidence and were not sufficiently supported to challenge poor behaviour, and bullying and intimidation by prisoners was rife. Many prison officers told us they feared for their safety and that morale was low.

1.6 The prison was not fulfilling its function as a category B trainer and prisoners spent far too long locked up. They were underemployed and very frustrated by the lack of opportunities for progression. A chronic shortage of prison officers remained at the heart of the prison's difficulties, with almost twice as many officers leaving than joining. Local leaders (see Glossary) urgently needed more support from HM Prison and Probation Service (HMPPS), and the prison needed a complete reset to make it a safe, decent and purposeful place.

What we found during this review visit

1.7 It is pleasing to report that at this review of progress, we found good or reasonable progress across all but one of the 10 concerns we raised. The prison population had been temporarily reduced by almost half, which had given the governor the space that she needed to try to reset the prison as we had suggested. The jail had successfully recruited, and, so far, retained, its full quota of officers, although some were still in training and the level of inexperience was very high. We found reasonable progress in most areas with respect to safety. Violence had reduced overall and, although self-harm remained the highest in the adult male estate, care for individuals at risk had improved. Arrangements for those in their early days at the prison were also now much better. While use of force had increased, scrutiny of incidents was considerably more thorough, although, disappointingly, we found no meaningful progress with the poor conditions and long stays for those held in segregation.

1.8 Prisoners spent more time unlocked and engaged in purposeful activity. Ofsted found reasonable progress in two themes they reviewed, but two remained insufficient. The curriculum still did not meet the needs of the population, and the careers information, advice and guidance needed to improve. We found good progress, however, in the support that prisoners received from the offender management unit, and key work had been relaunched. There was also good progress in health care, which included addressing the regulatory concerns that had been raised by the Care Quality Commission.

1.9 Overall, this was an encouraging review. The governor, her senior team and staff should be congratulated on what they have achieved so far in addressing the shortcomings identified in the Urgent Notification. However, continuing support from senior HMPPS leaders will be critical to sustaining the fragile progress identified. Affording the newly recruited staff group the space to gain experience in managing the prison's complex and challenging population will be vital for the

progress to become fully embedded and improve outcomes for prisoners.

Charlie Taylor
HM Chief Inspector of Prisons
August 2024

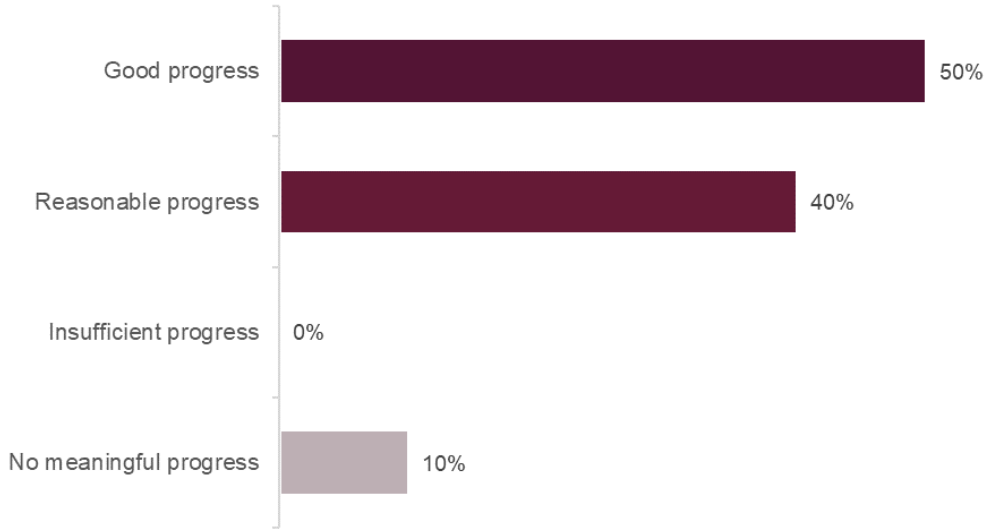
Section 2 Key findings

2.1 At this IRP visit, we followed up 10 concerns from our most recent inspection, in August 2023, and Ofsted followed up four themes. The CQC followed up on the Requirement Notices issued at that inspection.

2.2 HMI Prisons judged that there was good progress in five concerns, reasonable progress in four concerns, insufficient progress in no concerns and no meaningful progress in one concern.

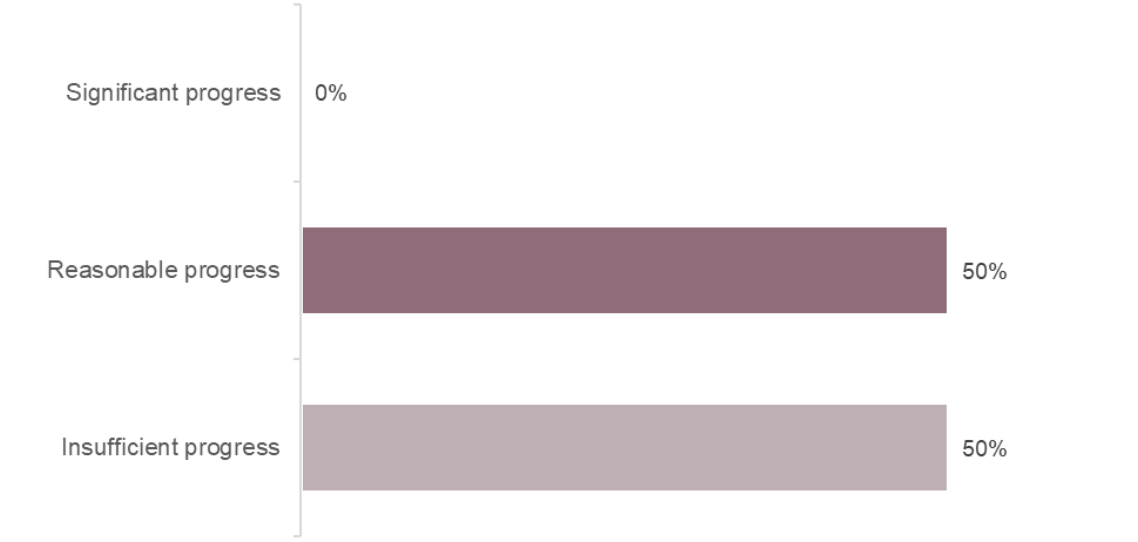
Figure 2: Progress on HMI Prisons concerns from August 2023 inspection (n=10)

This bar chart excludes any concerns that were followed up as part of a theme within Ofsted's concurrent prison monitoring visit.



2.3 Ofsted judged that there was significant progress in no themes, reasonable progress in two themes and insufficient progress in two themes.

Figure 3: Progress on Ofsted themes from August 2023 inspection (n=4).



Notable positive practice

2.4 We define notable positive practice as:

> Evidence of our expectations being met to deliver particularly good outcomes for prisoners, and/or particularly original or creative approaches to problem-solving.

2.5 Inspectors found two examples of notable positive practice during this IRP visit, which other prisons may be able to learn from or replicate. Unless otherwise specified, these examples are not formally evaluated, are a snapshot in time and may not be suitable for other establishments. They show some of the ways our expectations might be met, but are by no means the only way.

Examples of notable positive practice		
a)	The introduction of 'peace promoters' (peer workers trained to carry out mediation) had helped to de-escalate situations of potential conflict in the prison.	See paragraph 3.24
b)	The routine, local auditing of in-possession risk assessments, covering all patient prescriptions, introduced by the lead pharmacist, along with the systematic approach to assuring compliance with prescribing standards, made sure that risk in this area was minimised and care enhanced.	See paragraph 3.54

Section 3 Progress against our concerns and Ofsted themes

The following provides a brief description of our findings in relation to each concern followed up from the full inspection in 2023.

Leadership

Concern: A severe shortage of officers was the fundamental strategic challenge facing the prison. It undermined almost all elements of delivery and limited the amount of time unlocked for prisoners, their access to activities and the care they received.

3.1 The full quota of band 3 officers had now been recruited, following an extensive campaign run by HMPPS. There was also a healthy pipeline of potential new recruits. Recruitment efforts had included localised advertising, recruitment fairs and an open day held at the prison. In-house prison officer training had also been introduced.

3.2 Staff retention had improved. In total, 149 officers had joined and 57 had left since the last inspection, compared with 56 joining and 96 leaving in the 12 months before the previous inspection. Leaders had increased staff support through weekly supervision or 'team time' for most house units, regular training and well-being events.

3.3 However, only around two-thirds of officers were currently available for operational duty; 45 were still training and a further 52 could not be deployed for other reasons, including suspension, temporary promotion and long-term sickness. Officers on detached duty (47) continued to supplement staffing at the prison.

3.4 The level of inexperienced officers was very high; 45% had less than one year's service, and 57% had less than two. The number of 'new colleague mentors' had increased from two to four, and new officers we spoke to said that they felt supported in their role.

3.5 The shortage of custodial managers (CMs) and supervising officers (SOs) was a critical gap. Although recruitment of SOs had improved, the position for CMs had worsened since the last inspection and only around half were in post.

3.6 The improvement in prison officer staffing, combined with the temporary reduction in operational capacity, had enabled more time unlocked for prisoners, improved access to activities and delivery of key work (see also sections on time out of cell and education, skills and work, and paragraph 3.91). Some prisoners told us about good care that they had received from staff, but others said that they experienced difficulties in getting issues resolved because of staff inexperience.

3.7 We considered that the prison had made good progress in this area.

Early days in custody

Concern: Early days arrangements were not good enough. Reception and first night processes were weak and induction was very poor.

3.8 Reception processes had been reviewed. Escort vehicles were now quickly moved to reception and the practice of handcuffing prisoners exiting the vehicles had stopped.

3.9 The reception area was clean and had been refurbished, and information about the prison was on display. A new induction risk assessment had been introduced and interviews with reception, safety and health care staff were now conducted in private.

Prisoner waiting area in reception

3.10 Peer advisers were available in reception to answer any questions and help prisoners understand how to use the self-service kiosk which had recently been installed.

3.11 The induction unit had moved to house unit 5, which had also been refurbished and had a dedicated induction room. An orderly was responsible for ensuring that all cells were clean and had the correct equipment, and this was then checked by staff before use. A 'decency box', which contained toilet rolls and toiletries, was also available on the wing.

Cell in induction unit

3.12 First night arrangements had improved. Before being locked up, prisoners were given a hot meal and shower, and were promptly introduced to Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) and 'peace promoters' (peer workers trained to carry out mediation; see also paragraph 3.24). They also received an induction booklet. New receptions were able to contact family using the in-cell telephone.

3.13 A structured induction programme for new arrivals started on the next working day. This was jointly delivered by enthusiastic peer workers and staff. Induction included presentations from the offender management unit (OMU), and the education, programmes, gym and substance misuse teams.

Induction unit association area

3.14 Laptops were issued to new prisoners within 72 hours of arrival and digital peer mentors were available to show prisoners how to access induction information and submit orders and applications.

3.15 Oversight of the delivery of the induction programme had improved. Managers had developed a tracking system, but further assurance was needed for those sessions completed off the wing, such as in the education department and the gym.

3.16 New receptions that we spoke to said that they had been given information on their laptop computers to help them understand what was happening in their first few days.

3.17 We considered that the prison had made good progress in this area.

Managing behaviour

Concern: Levels of violence between prisoners and against staff were among the highest for any prison in England and Wales. An inexperienced staff group lacked the confidence to challenge poor behaviour by prisoners and there were too few incentives throughout the prison to promote pro-social behaviour. The widespread availability of illicit drugs was also a significant causal factor.

3.18 Overall, the average rate of violence for the last six months had reduced substantially when compared with the same period before the last inspection. The rate of serious assaults against staff had also reduced, but remained the highest in the adult male estate.

3.19 The number of prisoners being supported by the challenge, support and intervention plan case management process (see Glossary) had appropriately increased since the last inspection, when we had found this underused. A quality assurance process had been introduced which made sure that targets were completed in a more timely way. Risks and targets associated with each prisoner were shared with wing staff using a one-page document called a 'know your prisoner guide', although staff knowledge of these was mixed.

3.20 At the time of our visit, nine prisoners were self-isolating. The regime remained poor for most; exercise in the open air was rarely offered and not all said that they had the opportunity to shower each day. Although reintegration plans were in place and a multidisciplinary meeting was held for all prisoners every 28 days to discuss the support they needed, these plans were not updated. However, prisoners received more meaningful contact with staff than at the time of the last inspection; records showed that daily electronic case notes by wing staff were usually completed, and a member of the safety team visited isolating prisoners each week.

3.21 The violence reduction tasking meeting to respond to emerging intelligence and concerns was held more regularly. Attendance had improved and actions were mostly completed on time.

3.22 The mandatory drug testing positive rate had decreased but was still high (28%) and drugs remained a contributing factor to violence. However, the prison had undertaken work to improve its understanding of the causes of violence and had developed an action plan to reduce the number of incidents further.

3.23 We observed instances of staff appropriately challenging prisoners who were displaying poor behaviour. There had been some incentives introduced to encourage positive behaviour, although prisoners told us that more was needed. The timeliness of reviews to move up and down the levels of the incentives scheme had improved.

3.24 The introduction of 'peace promoters' (see also paragraph 3.12) had been a positive initiative and some prisoners told us that these individuals had helped to de-escalate situations of potential conflict.

'Peace promoter' (photograph provided by HMP Woodhill)

3.25 We considered that the prison had made reasonable progress in this area.

Concern: The amount of force used by staff on prisoners was very high. There was too little scrutiny for leaders to be confident that all use of force was justified.

3.26 Overall, the level of use of force in the last six months, compared with the equivalent period before the last inspection, had increased and was among the highest in all adult male prisons. Most incidents of force had been to prevent an assault or return a prisoner to their cell if they had refused to go. Around half of the incidents were low level and had not resulted in the use of full control and restraint.

3.27 Although there had been a spike of incidents in May 2024, which the prison had linked to an influx of psychoactive substances, there were early indications that use of force was starting to decrease. The use of PAVA (see Glossary) and batons had reduced.

3.28 Scrutiny meetings were now held weekly and 100% of incidents were reviewed. The meeting continued to be in-depth, identifying learning and good practice, which was shared with staff. There had also been an increase in the use of body-worn video cameras; local data showed that these had captured 82% of incidents in the last three months.

3.29 The use of force coordinator was no longer cross-deployed, and all prisoners involved in incidents of force were offered an opportunity to attend a post-incident debrief to discuss why the incident had occurred.

3.30 The use of unfurnished accommodation had reduced, but the justification for the use of anti-ligature clothing was not always fully recorded.

3.31 We considered that the prison had made reasonable progress in this area.

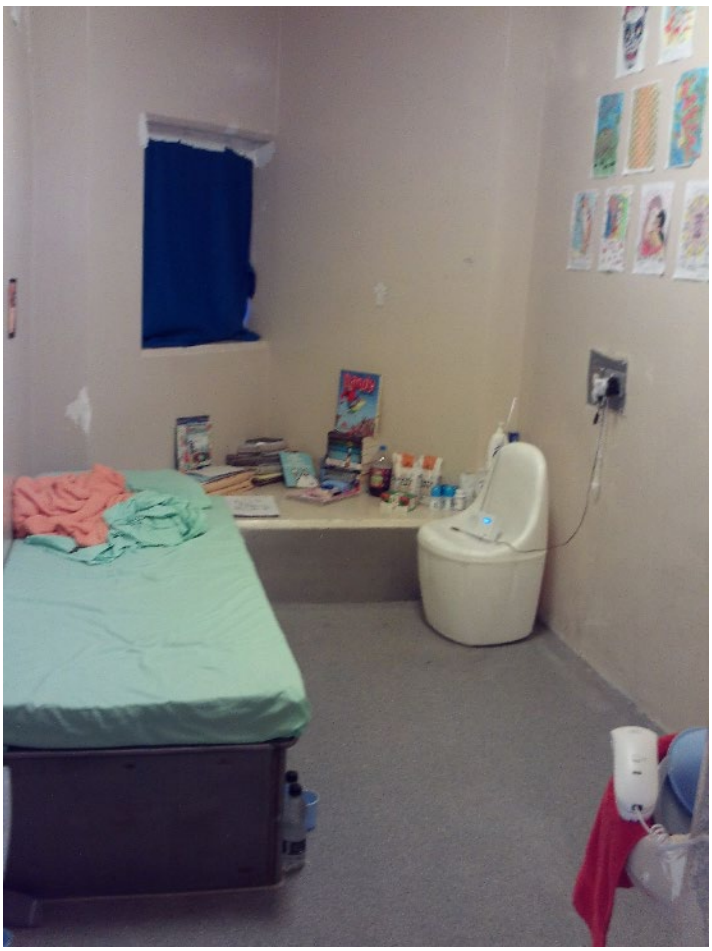
Concern: Too many prisoners were segregated for excessive periods, in rundown conditions, with access to only a limited regime and little reintegration planning.

3.32 The segregation unit remained full, and the adjoining overflow facility continued to be used. In the last six months, there had been 69 prisoners segregated, which was similar to number in the same period before the last inspection (72).

3.33 At the time of our visit, we found two prisoners who had remained segregated for over a year.

3.34 Segregation monitoring remained a concern as data on length of stay were not accurately recorded. The segregation monitoring meeting had increased in frequency from quarterly to monthly, which gave better accountability, but issues such as the consistently large numbers of segregated prisoners and their long stays were not addressed.

3.35 There were also no data available on the number of prisoners reintegrated back to wings, but staff told us that 12 of the 17 currently held were refusing to relocate.



Segregation cell

3.36 The authority to segregate was completed appropriately and reviews were on time, but behavioural target setting was poor and often did not relate to reducing risk. Reintegration planning had taken place for a few, but more needed to be done to encourage prisoners out of cells who had been isolated for long periods.

3.37 The environment remained run down and some areas of the unit were dirty. Prison leaders did not routinely monitor cleanliness.

3.38 The regime on the unit was poor. At the time of the last inspection, prisoners had been allowed between 45 minutes and an hour of exercise a day, but this had reduced to 30 minutes and prisoners were rarely able to collect their own meals. More positively, they could now shower daily and had a laptop computer and telephone in their cell. Some completed in-cell education packs and were paid an extra £4 a week.

Segregation unit communal shower

3.39 Professionals visiting prisoners still had nowhere to speak to them in private. Leaders told us that there were plans to convert a cell into an interview room.

3.40 During the last six months, 39 prisoners had experienced segregation conditions on the wings, usually while waiting for adjudications. Risk assessments were poorly completed and it was unclear how long prisoners had spent locked in their cells or the regime that they had been given. Management oversight of the system was weak.

3.41 We considered that the prison had made no meaningful progress in this area.

Safeguarding

Concern: Levels of self-harm were the highest in the adult male estate. The care and support given to those in crisis was not consistently good enough.

3.42 While the rate of self-harm had declined slightly since the last inspection, it remained the highest in the adult male estate. There had

been 237 incidents of self-harm in the last six months, and one self-inflicted death since the last inspection.

3.43 The safer custody team had expanded since the last inspection, and assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm had improved. ACCT documentation we reviewed was generally of reasonable quality and most reviews were now conducted by the same case manager, which was positive.

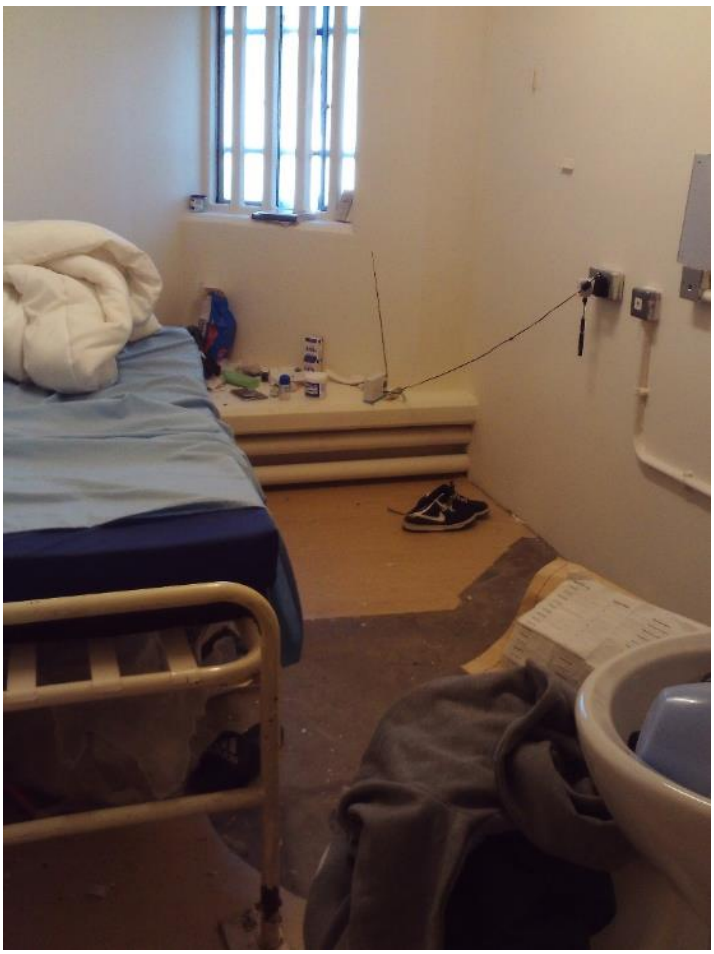
3.44 Quality assurance processes had also been implemented for ACCT case management, and safer custody supervising officers now visited wings to provide support and feedback.

3.45 While some prisoners supported by ACCT case management, particularly those on the Compass unit (a residential reintegration and additional needs unit within the health care department), spoke positively about the support they received, others expressed frustration that their concerns were not being addressed by wing staff.

3.46 There had been 12 uses of constant supervision in the last six months. The constant supervision cell in the segregation unit continued to be used in the absence of available alternatives on housing units, and individuals held there received a very limited regime. The unit's constant supervision facility, although cleaner than at the time of the last inspection, remained austere. The prison had received investment for two additional constant supervision cells to alleviate this issue.

Segregation unit constant supervision facility at the last inspection (left) and at this visit (right)

3.47 We found one individual under constant supervision on a housing unit, being held in a cell that was not fit for purpose, with large sections of flooring missing and a leaking sink. We were told that refurbishment was planned imminently, although it was disappointing that the cell was in use in the interim.



Constant supervision cell in poor condition

3.48 Listeners were generally positive about being able to see prisoners, and the support they received from staff, although we were told of instances where prisoners had been provided with the Samaritans telephone number as an alternative to a Listener call-out, which was not appropriate.

3.49 We considered that the prison had made reasonable progress in this area.

Health, well-being and social care

Concern: Prisoners who were acutely unwell, including those who had taken an overdose of illicit drugs and were assessed as an emergency, were not receiving care that met the national guidelines for clinical monitoring or escalation of concerns.

3.50 We found a well-led, cohesive health leadership team which had established a clear plan to address the key concerns and Care Quality Commission (CQC) breaches of regulations we identified at the last inspection. This approach had seen staffing stabilised and revised policies and practices introduced, which had embedded more effective, evidence-based support for prisoners who were found to be unwell or

under the influence of illicit substances. We found that, in these circumstances, clinical monitoring of patients' needs was being appropriately undertaken, in line with their presentation.

3.51 All health care staff had received training in the use of National Early Warning Score 2 (NEWS2), to make sure that standards of competency were established for the monitoring of patients' essential vital signs.

3.52 When used, NEWS2 assessments were discussed at the daily handover meetings, which enabled senior clinicians to monitor practice and intervene further if needed. Impressive local assurance systems, including systematic audit, made sure that standards were monitored and enhanced support was provided to practitioners if needed. Regular exercises to gauge health care staff responses to potential emergency medical scenarios had been introduced since the last inspection. This enabled competencies to be tested in a safe and supportive manner, with input from front-line prison officers.

3.53 We considered that the prison had made good progress in this area.

Concern: Prisoners did not have up-to-date assessments of their medication risks and needs, and the queues at the dispensing hatch were not properly supervised. There was therefore loss of confidentiality and a risk of diversion.

3.54 The lead pharmacist had introduced an excellent monitoring system which flagged when a patient's in-possession risk assessment (IPRA) review was due. Local audit led to the primary care lead being tasked to resolve any cases identified as needing an IPRA review. Compliance was subsequently monitored at the weekly leadership team meeting until the review was completed. As a result, the backlog had been eradicated, and our sampling of a large number of clinical records demonstrated that every prisoner had a completed and viable IPRA recorded.

3.55 The supervision of queues at medicines dispensing hatches had improved. Clear guidance had been provided for prison officers and all of those we spoke to were fully aware of their responsibilities. There was no crowding by prisoners around the hatches and throughput was managed safely by the staff assigned to these duties. Front-line health care practitioners confirmed that they would cease medicine administration if no officers were available to provide support, which would reduce opportunities for medicines to be diverted.

3.56 We considered that the prison had made good progress in this area.

CQC regulatory concern: Regulation 17

- Staff failed to follow the Trust's incident and serious incident policy.
- The Trust's Standard Operating Procedure for the use of Oxehealth (non-contact technology) in the Clinical Assessment Unit (CAU) at HMP Woodhill did not require consent on an individual basis or when a best interest decision should be made.

3.57 We reviewed the Trust's response to the criticism of incident management arrangements which emerged at the last inspection. The Trust had changed the threshold for reporting and this enhanced approach provided the required assurance that relevant adverse incidents – including all unplanned admissions to hospital – were being fully documented and reviewed appropriately. In addition, learning from such incidents was systematically shared with staff.

3.58 The Trust had adopted a robust approach to seeking patient consent for the use of Oxehealth monitoring (a non-contact physical health monitoring of vital signs) within the CAU. Patients in the CAU said that they had been told about the Oxehealth system – an overview of which was detailed in a patient information leaflet. Furthermore, within individual clinical records we saw well-documented evidence of patients' views being captured and respected unless they lacked capacity to make an informed decision. In such situations, best interest decisions were appropriately made in a multidisciplinary setting.

Time out of cell

Concern: Prisoners spent far too long locked up. The regime was not working, with activities regularly cancelled, so that even employed prisoners were frequently locked up for more than 21 hours each day. At weekends all prisoners were locked up for almost all the time.

3.59 The regime was more predictable than at the time of the last inspection, and prisoners were now able to attend activities more consistently.

3.60 Around 47% of the population were now in full-time employment, and time out of cell (see Glossary) had improved for these prisoners. Our roll checks found around a third of prisoners engaged in off-wing activity, compared with less than a quarter at the last inspection.

3.61 However, time out of cell had worsened for those who were not in employment or were unable to work, amounting to around a fifth of the population. These prisoners typically received less than two hours out of their cells each weekday, and those on the basic level of the incentives scheme received even less.

3.62 Prisoners now received only up to 30 minutes of outside exercise each day, which was not enough. There were pool tables and bookshelves available on the residential units, but there were still few enrichment activities taking place.

Recreation equipment on a housing unit

3.63 Time out of cell at weekends had slightly improved. Full-time workers and enhanced prisoners now had 4.25 hours unlocked and additional gym sessions, but standard prisoners still spent around 21 hours a day locked up.

3.64 The library was now open, but access for prisoners not engaged in education remained poor. The library team continued to provide outreach to the wings, supplemented by small bookcases on the units.

Library orders for wing delivery (left) and housing unit bookshelf (right)

3.65 We considered that the prison had made reasonable progress in this area.

Education, skills and work

This part of the report is written by Ofsted inspectors. Ofsted's thematic approach reflects the monitoring visit methodology used for further education and skills providers. The themes set out the main areas for improvement in the prison's previous inspection report or progress monitoring visit letter.

Theme 1: What progress had leaders and managers made in ensuring the curriculum is sufficiently ambitious and challenging to meet the needs of the prison population?

3.66 In the last 11 months, since the previous inspection, leaders had not provided a sufficiently challenging and ambitious curriculum. Too many prisoners were not involved in activities that built on their knowledge and skills to prepare them for their next steps. For example, leaders did not provide opportunities for prisoners working in industries and workshops to gain qualifications or recognise their skills sufficiently in these areas. As a result, prisoners did not make quick enough progress in this training prison.

3.67 Instructors did not monitor prisoners' progress effectively or set them challenging targets. As a result, prisoners were not sufficiently aware of the knowledge and skills they gained at work and made little progress.

3.68 Leaders did not make sure that prisoners had sufficient opportunities to complete higher-level qualifications in subjects which would help them to prepare for employment on release. Leaders had carried out a review of the curriculum, but the range of courses on offer remained too narrow. The small number of vocational courses in multi-skills, painting and decorating, and catering were only available up to level 2. Leaders did not offer enough meaningful qualifications for prisoners serving long sentences, or enough challenging opportunities for those who had previous experience. They had planned to offer additional courses such as study skills to help prisoners progress to level 3, but they were not yet implemented. Staff had promoted distance learning courses to prisoners, which had led to a large increase in applications, but a few prisoners had not received the support they needed to apply for these courses.

3.69 A few prisoners benefited from demanding content in courses, such as in music technology. As a result, they quickly honed their skills in writing, producing, recording and editing their own music.

3.70 Ofsted considered that the prison had made insufficient progress against this theme.

Theme 2: What progress had leaders and managers made in providing sufficient opportunity for prisoners to improve their skills in English and mathematics, and give those with complex needs or with learning difficulties and/or disabilities the support they need?

3.71 Since the previous inspection, leaders and managers had increased the opportunities for prisoners to learn English and mathematics. This included routes for them to progress from lower levels, including entry-level English for speakers of other languages, to level 2. Leaders had doubled the number of spaces available for prisoners to attend classes since the start of 2024. Prisoners who could not attend education could complete learning in English and mathematics through outreach support.

3.72 Staff checked prisoners' knowledge and skills in English and mathematics appropriately when they arrived at the prison and placed them onto the right level. Most prisoners gained new English and mathematics skills and could recall what they had learned well. Teachers mostly used effective techniques to help prisoners remember what they were taught. However, in mathematics not all prisoners were supported effectively to understand new concepts. Most prisoners achieved their qualifications, and many progressed to the next level of qualification. In industries, staff did not set specific or challenging enough literacy and numeracy targets and tasks to help prisoners improve their skills.

3.73 Leaders had improved the assessment of prisoners with additional learning needs. They identified prisoners' needs and had put appropriate support plans in place. Leaders had recruited specialist staff to support prisoners who had additional needs. Leaders had trained education staff and instructors to understand the potential barriers that prisoners faced. They had made sure that staff shared information and provided consistently suitable support. As a result, prisoners with additional learning needs or disabilities achieved their qualifications as well as their peers.

3.74 Peer mentors were keen and motivated to help prisoners progress. However, they did not always receive clear direction by tutors about what support to provide. As a result, they did not consistently give prisoners effective support.

3.75 Ofsted considered that the prison had made reasonable progress against this theme.

Theme 3: What progress had leaders and managers made to ensure that sufficient purposeful activity was offered to occupy prisoners fully for the core week, and to make sure that prisoners arrive on time?

3.76 Leaders had increased the number of sessions available in education for prisoners to attend for the full core day for four days per week. They had increased the offer of courses in English for speakers of other languages, English and mathematics, and given prisoners opportunities to combine part-time education with part-time work. Prisoners valued the opportunity to work and further their studies. Leaders had introduced additional work roles since the previous inspection. While the proportion of prisoners in full-time activity had increased, there were still not enough spaces available to occupy the population for the whole of the core week. As a result, too many prisoners were still not improving their skills during their time at the prison.

3.77 Leaders had improved their use of the spaces available in education and work, and had filled over four-fifths of them. They had promoted and incentivised the opportunities for education, skills and work at the prison. This had resulted in a notable number of prisoners applying for distance learning courses, although these had not yet started. Managers had started to allocate unemployed prisoners to roles when they identified something suitable. Prisoners who had been allocated enjoyed their new responsibilities. There were enough part-time activities for all prisoners to take part. Just under two-thirds of the population were taking part in full-time activity. Leaders were reviewing the number of spaces on offer in work areas, with the aim of employing more prisoners in existing work roles and had plans to increase the number of roles and education spaces.

3.78 Through the establishment of a more consistent regime, leaders had improved punctuality to education and work, although too many prisoners did not begin their activities on time. Too many prisoners left work or education early to attend gym sessions. Leaders had introduced roving patrol officers to return prisoners to education or work from other appointments. This reduced the number of prisoners missing out on their work and study time.

3.79 Ofsted considered that the prison had made reasonable progress against this theme.

Theme 4: What progress had leaders and managers made to make sure prisoners received high quality careers information, advice and guidance to make informed and realistic decisions about their futures?

3.80 Leaders had recently started to monitor the quality of information, advice and guidance (IAG) provision. They had not provided information, advice and guidance of sufficiently high quality to meet the needs of the population. Recently recruited IAG staff had completed a large proportion of the backlog of personal learning plans with

prisoners, with nearly all prisoners having a plan in place. Leaders had not made sure that the information given to prisoners was of a consistently high enough standard. Managers were starting to use the information in the plans to allocate prisoners to activities which aligned with their goals, but in too many instances this was not the case.

3.81 Leaders had created prisoner information, advice and guidance roles, but the prisoners in these roles had not received sufficient training to fulfil the responsibilities effectively. They met with peer prisoners before having sufficient information to be able to give comprehensive advice. In most instances, staff did not set prisoners suitable targets to help them to improve. Very few prisoners recalled having meaningful discussions to help them make informed decisions. Many were not clear about why they were on courses or did not know what their course or job was preparing them for, other than allowing for them to have time off their housing units.

3.82 Leaders had not made sure that staff or prisoners knew about or understood the newly introduced career pathways. As a result, prisoners were taking part in a mixture of courses and work roles which did not align with their career aspirations. There was no clear line of sight for prisoners to access more advanced work or study opportunities beyond mentor roles. Leaders and managers did not work with employers to advise prisoners about the types of roles available to them in their next steps.

3.83 Ofsted considered that the prison had made insufficient progress against this theme.

Reducing reoffending

Concern: Many prisoners were frustrated about the lack of opportunities to progress in their sentence. Contact between prison offender managers and prisoners was sporadic and key work was non-existent.

3.84 The prisoners we spoke to were far more positive about the support they received from the OMU than at the time of the last inspection.

3.85 Probation-trained prison offender manager (POM) staffing levels had nearly doubled, and caseloads had reduced and were now more manageable.

3.86 The frequency of contact between POMs and prisoners had generally improved and was more aligned to OMiC national standards (see Glossary).

3.87 The continued delivery of monthly OMU wing-based clinics was positive, and in-cell laptop computers enabled prisoners to communicate easily and quickly with a POM.

3.88 The sequencing of offence-related interventions was necessary, given that most of the population were serving long sentences. Contact was

now better focused on driving sentence progression at appropriate intervals beyond the typical time-bound tasks, such as upcoming parole hearings and categorisation reviews.

3.89 A co-working arrangement remained in place, whereby probation-employed POMs held some of their cases as the named offender manager but devolved day-to-day case management responsibility to the prison-employed POM working under their supervision. While some high-risk prisoners were still not receiving the skilled intervention of a probation officer, all POMs worked professionally and effectively together to support and guide each other when managing complex cases.

3.90 Nearly all prisoners had an initial assessment of their risk and needs, and the timeliness of these reviews had improved. The quality of sentence plans remained reasonably good.

3.91 Key work had relaunched in January 2024, and most prisoners now had an allocated key worker. The frequency and quality of contacts were steadily improving, and we saw examples of some good key work entries that were supportive of offender management.

3.92 Leaders had implemented evolving but effective arrangements to oversee and drive continuous improvements in both key work delivery and POM contact. This included assigning key work champions and responsible leads, delivering staff awareness raising sessions and undertaking regular quality assurance.

Key work display board

3.93 We considered that the prison had made good progress in this area.

Section 4 Summary of judgements

A list of the HMI Prisons concerns and Ofsted themes followed up at this visit and the judgements made.

HMI Prisons concerns

A severe shortage of officers was the fundamental strategic challenge facing the prison. It undermined almost all elements of delivery and limited the amount of time unlocked for prisoners, their access to activities and the care they received.
Good progress

Early days arrangements were not good enough. Reception and first night processes were weak and induction was very poor.
Good progress

Levels of violence between prisoners and against staff were among the highest for any prison in England and Wales. An inexperienced staff group lacked the confidence to challenge poor behaviour by prisoners and there were too few incentives throughout the prison to promote pro-social behaviour. The widespread availability of illicit drugs was also a significant causal factor.
Reasonable progress

The amount of force used by staff on prisoners was very high. There was too little scrutiny for leaders to be confident that all use of force was justified.
Reasonable progress

Too many prisoners were segregated for excessive periods, in rundown conditions, with access to only a limited regime and little reintegration planning.
No meaningful progress

Levels of self-harm were the highest in the adult male estate. The care and support given to those in crisis was not consistently good enough.
Reasonable progress

Prisoners who were acutely unwell, including those who had taken an overdose of illicit drugs and were assessed as an emergency, were not receiving care that met the national guidelines for clinical monitoring or escalation of concerns.
Good progress

Prisoners did not have up-to-date assessments of their medication risks and needs, and the queues at the dispensing hatch were not properly supervised. There was therefore loss of confidentiality and a risk of diversion.
Good progress

Prisoners spent far too long locked up. The regime was not working, with activities regularly cancelled, so that even employed prisoners were frequently locked up for more than 21 hours each day. At weekends all prisoners were locked up for almost all the time.
Reasonable progress

Many prisoners were frustrated about the lack of opportunities to progress in their sentence. Contact between prison offender managers and prisoners was sporadic and key work was non-existent.
Good progress

Ofsted themes

The education curriculum delivered was not sufficiently ambitious or challenging to meet the needs of the prison population.
Insufficient progress

Too few prisoners had sufficient opportunity to raise their levels of skill in English and mathematics, and those with complex needs or with learning difficulties and/or disabilities were not given the necessary support.
Reasonable progress

Insufficient purposeful activity was offered to occupy prisoners fully for the core week and punctuality at the activity sessions that did take place was poor.
Reasonable progress

The careers information, advice and guidance arrangements were insufficient to provide prisoners with the help they needed to make informed and realistic decisions about their futures.
Insufficient progress

Appendix I About this report

HM 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, court custody and military detention.

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.

Independent reviews of progress (IRPs) are designed to improve accountability to ministers about the progress prisons make in addressing HM Inspectorate of Prisons' concerns in between inspections. IRPs take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny and focus on a limited number of the concerns raised at the inspection. IRPs do not therefore result in assessments against our healthy prison tests. HM Inspectorate of Prisons' healthy prison tests are safety, respect, purposeful activity and rehabilitation and release planning. For more information see our website: https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/

The aims of IRPs are to:

- assess progress against selected priority and key concerns
- support improvement
- identify any emerging difficulties or lack of progress at an early stage
- assess the sufficiency of the leadership and management response to our concerns at the full inspection.

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each concern we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in August 2023, for further detail on the original findings (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/).

IRP methodology

IRPs are announced at least three months in advance and take place eight to 12 months after a full inspection. When we announce an IRP, we identify which concerns we intend to follow up (usually no more than 15). Depending on the concerns to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

During our three-day visit, we collect a range of evidence about the progress in implementing each selected concern. Sources of evidence include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

Each concern followed up by HMI Prisons during an IRP is given one of four progress judgements:

No meaningful progress
Managers had not yet formulated, resourced or begun to implement a realistic improvement plan to address this concern.

Insufficient progress
Managers had begun to implement a realistic improvement strategy to address this concern but the actions taken since our inspection had had not yet resulted in sufficient evidence of progress (for example, better and embedded systems and processes).

Reasonable progress
Managers were implementing a realistic improvement strategy to address this concern and there was evidence of progress (for example, better and embedded systems and processes) and/or early evidence of some improving outcomes for prisoners.

Good progress
Managers had implemented a realistic improvement strategy to address this concern and had delivered a clear improvement in outcomes for prisoners.

When Ofsted attends an IRP its methodology replicates the monitoring visits conducted in further education and skills provision. Each theme followed up by Ofsted is given one of three progress judgements.

Insufficient progress
Progress has been either slow or insubstantial or both, and the demonstrable impact on learners has been negligible.

Reasonable progress
Action taken by the provider is already having a beneficial impact on learners and improvements are sustainable and are based on the provider's thorough quality assurance procedures.

Significant progress
Progress has been rapid and is already having considerable beneficial impact on learners.

Ofsted’s approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook*, available at https://www.gov.uk/government/publications/education-inspection-framework.

Inspection team

This independent review of progress was carried out by:

Sara Pennington	Team leader
Jade Richards	Inspector
Natalie Heeks	Inspector
Rick Wright	Inspector
Dawn Mauldon	Inspector
Steve Eley	Health and social care inspector
Janie Buchanan	Care Quality Commission inspector
Rebecca Jennings	Ofsted inspector
Jane Hughes	Ofsted inspector

Appendix II Glossary

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

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

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

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

Offender management in custody (OMiC)
The Offender Management in Custody (OMiC) model, which has been rolled out in all adult prisons, 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.

OMiC national standards
Three contacts within the first three months of arrival; three contacts in the 12 weeks leading up to any potential release, with contact in between based on risk, need and responsivity.

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

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.

Urgent Notification
Where an inspection identifies significant concerns about the treatment and conditions of detainees, the Chief Inspector may issue an Urgent Notification to the Secretary of State within seven calendar days stating the reasons and identifying issues that require improvement. The Secretary of State commits to respond publicly to the concerns raised within 28 calendar days.

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

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

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