Report on an independent review of progress at

HMP Bedford

by HM Chief Inspector of Prisons

16–18 September 2024

Contents

Section 1 Chief Inspector's summary

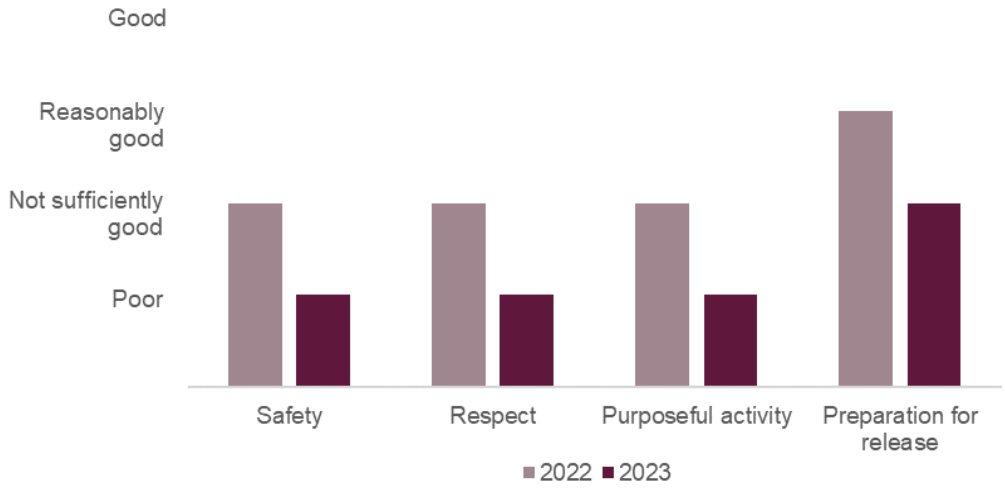
1.1 HMP Bedford is a category B Victorian local prison with a reception and resettlement function. It accommodates young adult and adult men, and has stood on its current site in the centre of Bedford since the early 19th century. It was enlarged in 1849, and in the early 1990s a new gate lodge, house block and health care centre were added. It accepts remanded and sentenced prisoners from the local Crown and magistrates' courts.

1.2 This review visit followed up on the concerns we raised at our last inspection of HMP Bedford in 2023 where we invoked the Urgent Notification protocol (see Glossary).

What we found at our last inspection

1.3 At our previous inspections of HMP Bedford in 2022 and 2023, we made the following judgements about outcomes for prisoners.

Figure 1: HMP Bedford healthy prison outcomes in 2022 and 2023
Note: rehabilitation and release planning became 'preparation for release' in October 2023.



1.4 At the last inspection of Bedford, we found that standards had deteriorated across every healthy prison test. We rated the jail as poor for safety, respect and purposeful activity, and not sufficiently good in preparation for release. This led us to invoke a second Urgent Notification to the Secretary of State, the first having been issued in 2018.

1.5 Standards of cleanliness on wings and in cells had been allowed to deteriorate, and filthy and dilapidated accommodation compounded the overcrowded conditions in which most prisoners were held. The underground segregation unit was not fit for human habitation.

1.6 Many officers and staff were inexperienced and too many were unavailable due to long-term sickness. This had had a detrimental effect on the delivery of core services in the jail.

1.7 Violence was among the worst of all adult prisons, levels of self-harm had increased, prisoners had little time out of cell, and most could not access any kind of purposeful activity. No key work (see Glossary) was being delivered and prisoners struggled to get simple things done.

What we found during this review visit

1.8 A new governor had been appointed less than seven months before this review visit. It was clear that she and the new deputy governor were taking the concerns raised at the last inspection seriously, but they acknowledged there was still much to do. Of the eight areas of concern that we assessed, progress was reasonably good or better in six and insufficient in two. Ofsted found reasonable progress in only one of the four themes it reviewed, and insufficient progress in the remaining three.

1.9 Senior leaders were now more visible around the prison, which was starting to drive up standards. After an extraordinary delay, the new segregation unit on B1 landing opened the week before our arrival and provided vastly improved conditions for prisoners and staff. The rest of B wing had also been renovated and provided better accommodation for prisoners on the highest level of the privileges scheme. The governor had raised the profile of work to ensure fair treatment and additional resources had been put in place; as a result, we found good progress in this area. Self-harm had reduced, key work was delivered more consistently, and support for prisoners with poor mental health was improving.

1.10 Despite some innovative work by the safety team, an already high rate of violence was going up, prisoners did not have enough to do and living conditions for most of them were still not good enough. The progress made by the governor and her leadership team was fragile and they will require extensive ongoing support from HMPPS to make the sustainable improvements the prison needs.

1.11 During this visit, Care Quality Commission inspectors found breaches of two regulations and issued requests for action plans (see Appendix III).

Charlie Taylor
HM Chief Inspector of Prisons
September 2024

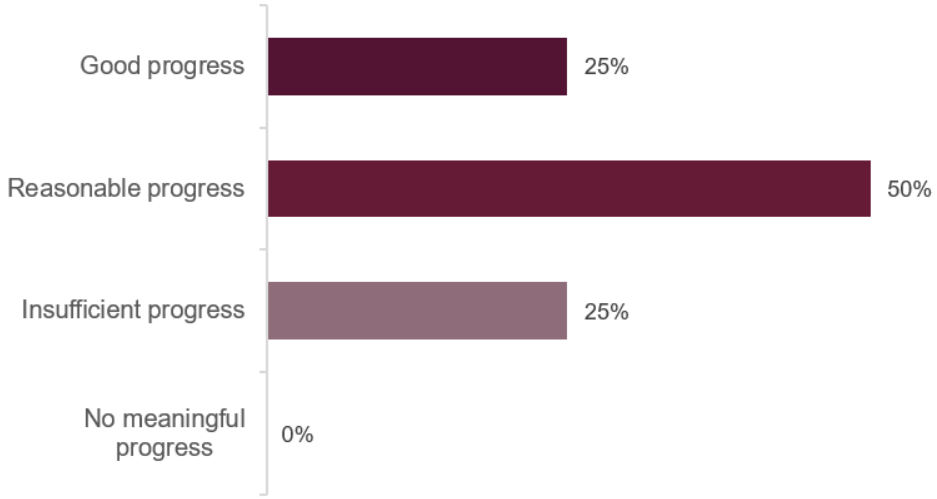
Section 2 Key findings

2.1 At this IRP visit, we followed up eight concerns from our most recent inspection in November 2023 and Ofsted followed up four themes based on their latest inspection or progress monitoring visit to the prison, whichever was most recent.

2.2 HMI Prisons judged that there was good progress in two concerns, reasonable progress in four concerns and insufficient progress in two concerns.

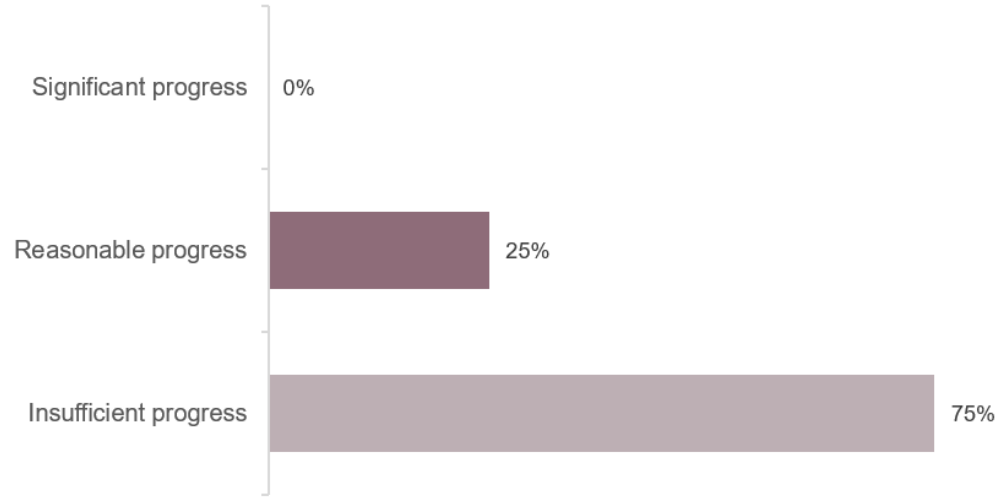
Figure 2: Progress on HMI Prisons concerns from November 2023 inspection (n=8)

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 reasonable progress in one theme and insufficient progress in three themes.

Figure 3: Progress on Ofsted themes from November 2023 inspection/progress monitoring visit (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 safety team held drop-in surgeries on residential units when intelligence had identified emerging issues. These provided a useful platform to give prisoners a voice, and an opportunity for staff to resolve issues before they became a bigger problem.	See paragraphs 3.13 and 3.23
b)	The governor and deputy governor, working with the new diversity and inclusion managers, had led by example in setting up and attending confidential discussions with staff and prisoners on issues of race and culture. This, in turn, had resulted in prisoner-led forums. Managers were finding ways to respond to the themes raised, without breaching confidentiality.	See paragraphs 3.44 and 3.47

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.

Early days

Concern: Care and support for prisoners in their early days had deteriorated. Time out of cell was poor, first night cells were dirty and the induction was not adequately organised or informative.

3.1 Leaders had made recent improvements in work to support prisoners in their early days. They had developed an action plan setting out what was required to improve outcomes further and how progress would be achieved.

3.2 Staff and peer supporters treated new arrivals to the prison with respect. Staff made sure that reception processes ran smoothly, and managers used an effective checklist to make sure that all necessary processes were complete, which had improved consistency.

3.3 There had been some limited redecoration in reception, but it remained a drab and unwelcoming environment. Some areas, including holding rooms, had been improved, but search areas and the shower cubicle still needed refurbishment.

3.4 Too many new arrivals still experienced long delays in reception, mainly due to the late arrival of escort vans.

3.5 The first night centre had been moved to a new location (E wing) eight weeks before the IRP. This unit was drab and needed refurbishment; although new flooring was due to be laid, extensive work would be required to make it a welcoming environment for prisoners new to custody. A small but functional day room, which incorporated the food servery, provided a relaxed area for prisoners to socialise.

3.6 Despite the poor environment, first night centre peer supporters made sure that cells were adequately equipped and helped prisoners to navigate through their first few days at the prison. The senior officer and dedicated first night centre officer demonstrated a good understanding of their role to support and guide new prisoners.

3.7 Staff and peer supporters delivered a regular induction programme which provided appropriate information. Induction was prompt and had input from a variety of departments, including information on housing and finance matters while in custody.

3.8 Time out of cell for prisoners on induction had improved, and was comparable to the main population, but it was still limited. This was somewhat offset by regular management meetings to make sure that most new prisoners moved promptly to general wings when their induction was complete. However, an overspill of prisoners held on the vulnerable prisoner unit meant that half of the first night accommodation was used to house vulnerable prisoners; many stayed on the unit for too long without an adequate regime, which was not appropriate.

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

Managing behaviour

Concern: Levels of violence, especially against staff, were very high. Much of this was fuelled by prisoner frustration at poor and inconsistent time out of cell and lack of response to legitimate requests through the application and complaints systems. Leaders did not deliver a full and purposeful regime that motivated prisoners to behave, engage or progress.

3.10 Violence between prisoners had increased during the previous six months, and the overall rates remained among the highest of all adult male prisons. The reduction in assaults against staff was encouraging, but the number remained high.

3.11 Leaders were taking a robust approach to managing the use of control and restraint on prisoners. They had focused on reducing the high number of assaults on staff that occurred during the use of force and had introduced effective measures to address this. All incidents of force were now reviewed, and appropriate action was taken where concerns were identified, including advice, support and further training. There had been firm action in a few cases where excessive force had been used. Leaders made good use of the old segregation unit to provide practical and regular scenario-based learning to develop their skills when dealing with incidents.

3.12 The security and safety teams were co-located and now worked more collaboratively, which had improved information-sharing and analysis of intelligence. The teams held regular triage meetings, and emerging risks of violence were discussed with residential staff at a daily safety intervention meeting (SIM) to make sure necessary action was taken promptly.

3.13 Leaders had introduced additional measures to understand and address the drivers of violence. A data-driven hot-spot strategy had included the introduction of safety-led drop-in surgeries for prisoners on residential units (see paragraph 3.23). When these forums identified issues contributing to violence, the safety team talked to staff and prisoners to develop a better understanding and seek solution. The

team was developing an action log and, while not all issues had been addressed, this was a proactive and innovative approach with much potential.

3.14 Leaders had addressed the weaknesses in the weekly SIM identified at the last inspection. The multidisciplinary meeting was well-attended, action-focused and addressed emerging issues on prisoners involved in violence or self-harm.

3.15 Referrals of prisoners to challenge, support and intervention plans (CSIPs, see Glossary) had improved, and all incidents of violence were investigated. However, investigations did not always evidence that all parties were spoken to, and targets were still too generic. For example, many targets were very broad, such as 'refrain from violence', and did not provide the prisoner nor staff with a clear pathway of what needed to be done to help support the individual. Similarly, reviews were not always effective in addressing the underlying issues leading to violence, and CSIPs were often closed without the original issues being resolved. Leaders had identified some of these shortfalls and an experienced member of staff from HMP Wayland had been deployed to advise and support staff in the management of CSIPs.

3.16 Despite improvements in the safety function, wider institutional problems had not been addressed sufficiently well to reduce the high levels of violence at Bedford. Time out of cell was more consistent but remained limited, too many prisoners were not purposefully occupied, and many remained frustrated by inefficiencies in some processes, including applications.

3.17 Drugs remained a significant threat to safety at Bedford. While there was evidence of some good wrap-around support from the substance misuse team, there had been no random drug testing in the last 12 months. This meant there was little data on drug use to inform intelligence or the adjudication process, so there was limited deterrent to the use or marketing of illicit substances.

3.18 Too few staff challenged low-level poor behaviour, such as when prisoners were clearly breaching rules on vaping in communal areas. More positively, part of B wing had been repurposed for prisoners on the highest level of the incentive scheme, who enjoyed more freedoms, access to trusted work areas and improved time out of cell.

3.19 We considered that the prison had made insufficient progress in this area.

Suicide and self-harm prevention

Concern: Care for prisoners at risk of self-harm or suicide was weak. ACCT reviews lacked a multidisciplinary approach and most were ineffective. Mental health referrals were too often overlooked.

3.20 There had been three deaths since our last inspection, one of which was self-inflicted, with another yet to be classified. Early learning reviews had been conducted, but leaders were not using the learning from Prisons and Probation Ombudsman (PPO) investigation reports effectively. For example, the concerns raised included weaknesses in the assessment, care in custody and teamwork (ACCT) case management process and obstacles to contact with family, but these had still not been fully addressed and created a risk to the future safety of prisoners.

3.21 The recorded rate of self-harm had decreased greatly since our last inspection. In the previous six months, there had been 172 incidents of self-harm, which equated to 480 incidents per 1,000 prisoners. This was a decrease of approximately 40% since we issued the Urgent Notification in 2023. While this was an encouraging reduction, numbers had started to rise again recently. Work to reduce self-harm had been supported by a manager from the regional office, which was improving oversight in this area.

3.22 Attendance at the monthly safety meeting remained inconsistent, but the analysis of data had improved and members demonstrated a better understanding of the drivers of self-harm. Leaders had identified that prisoner frustrations related to the regime, a lack of good-quality purposeful activity and poor mental health were contributing to self-harm.

3.23 The improved analysis of data had led to a range of purposeful and targeted actions to support the reduction in self-harm. For example, a questionnaire had been issued to staff to identify strengths and weaknesses in current practice, with a plan to use the findings to inform key priorities and improve training. Leaders had also introduced safety-led drop-in surgeries on residential units to develop a better understanding of the issues and find solutions in areas where there were higher levels of self-harm (see paragraph 3.13).

3.24 Despite the reduction in self-harm, there had been an increase in incidents deemed as near misses or requiring hospital attendance, with eight incidents in the previous six months compared with six in the 12 months before the full inspection. We were not assured that there had been thorough investigations in all cases, which limited opportunities to learn and reduce future incidents.

3.25 Leaders had appointed a full-time ACCT ‘floor walker’ to oversee the process and improve the quality of support offered to prisoners in crisis. Despite this, the quality of ACCTs was not good enough to ensure

good care. We observed some improvement in case reviews, including attendance from a qualified mental health practitioner at the first review, and more consistent case management. However, care plans contained few actions, there was a lack of detail on day-to-day records, and frequently missed daily supervisor checks.

3.26 Support from the mental health team for prisoners in crisis was improving, with all referrals triaged daily by the duty nurse on shift (see paragraph 3.54).

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

Staff-prisoner relationships

Concern: Staff did not develop effective relationships with prisoners. Key work was not being delivered and prisoners lacked faith in the ability of staff to resolve legitimate concerns.

3.28 Prisoners described two distinct groups of staff and managers at Bedford. One group were working hard to improve communication and a sense of community between staff and prisoners - for example, we saw some staff talking freely with prisoners and playing chess or table tennis with them while building a positive rapport. The other group, who would potentially influence new staff, were clearly more comfortable with an old-fashioned sense of distance and formality. Leaders understood the importance of good relationships and the need to increase the number of staff who fell into the first group if relationships were to improve at a faster pace.

3.29 We observed first-line managers giving some good support to staff, in commending good practice and advising on procedures, and coaching was available both through a national team and local mentoring. However, many staff had been temporarily promoted into supervisory and management grades after very limited operational experience, and they were less able than experienced managers to give solid support to the professional development of staff. Staff were not always enforcing wing rules or supervising wing workers effectively. Prisoners also experienced delays in getting things done, depending on which staff were on duty.

3.30 It was encouraging, however, that the delivery of key work (see Glossary) had improved since the full inspection, especially in the last two months, helped by higher staffing levels. Almost all prisoners, 94%, now had an allocated key worker compared with 28% at the full inspection. Certain vulnerable or high-risk groups were prioritised appropriately for weekly key worker support. HMPPS had assessed the quality of key work as better than at most reception prisons, and local quality assurance was now under way. Many more key worker entries on prisoners' electronic case notes now had relevant content and, as a whole, they gave a good picture of each prisoner's progress.

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

Living conditions

Concern: Many cells needed refurbishment and/or redecoration, many prisoners were held in mouldy cells, with broken windows and graffiti. Living conditions in the segregation unit were squalid**.** There was evidence of mould and infestation of rats and cockroaches.

3.32 At the full inspection we reported that living conditions were among the worst we had seen. During this visit it was clear that leaders had prioritised work to improve conditions on the residential units, and the standard of cleanliness had improved. However, these improvements were from a very low base and there was still much to do to make sure that all prisoners lived in decent and respectful conditions.

Examples of improvements still needed in cells

3.33 Staff now carried out regular decency checks, including a recently introduced senior management check. Progress and outstanding issues were recorded on a tracking sheet. The head of the residential function maintained oversight of the schedule of works to address identified shortfalls.

3.34 Leaders had identified cleanliness as an establishment priority, and their visibility on residential units was leading to improvement. However, too many communal areas still needed a deep clean and prisoners were not actively encouraged to maintain high standards in their cells.

3.35 After a significant delay, the new segregation unit had opened the week before our visit and provided much-improved living conditions for prisoners. The unit was clean and well-kept. When we visited, some segregated prisoners were banging and causing disruption, which made it difficult for the enhanced-status prisoners living on the landing above the unit to sleep. Leaders had identified the problem caused by

the lack of soundproofing, but had been unable to board up the stairwell to block out noise because of fire regulations; this was due to be addressed.

Segregation wing (left) and segregation cell (right)

3.36 The renovation of B wing had provided better accommodation for enhanced prisoners. It was cleaner than many other units and prisoners reported fewer sightings of cockroaches.

B wing

3.37 A windows replacement programme was under way with two units completed, but many cell windows across the establishment were still in disrepair.

3.38 A contractor had been appointed to resolve the deep-rooted damp problems and there had been a notable improvement. A painting programme had significantly reduced graffiti in cells.

3.39 The CRED (clean, rehabilitative, enabling, decent) programme, which involved prisoners in work to maintain a decent living environment, was working more effectively. The CRED team had supported the renovation of B wing and had commenced minor maintenance work across the rest of the establishment.

3.40 Despite work to eliminate cockroaches, they remained a problem on many wings. Prisoners continued to resort to creating their own barriers (plugging holes with plastic bags) to prevent them from coming into their cells.

3.41 Living conditions on some wings remained tired and worn, including the first night centre (see paragraph 3.5), the health care unit and the young adult wing. Leaders were sighted on the scale of the problem. They understood that the reasonable progress made to date would not necessarily equate to reasonably good outcomes in a full inspection and there was still much to do.

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

Fair treatment and inclusion

Concern: Prisoners, staff and managers reported witnessing racism. Systems to ensure fair treatment and inclusion were weak.

3.43 At the full inspection, diversity and inclusion had not been a priority for leaders and there had been no substantive lead in post for this area. At this IRP, two new diversity and inclusion managers were in post and receiving support from the regional lead. They demonstrated energy and dedication to their roles, and had a high profile among both staff and prisoners. Prisoners told us that they trusted them to take up and resolve their issues.

3.44 One sign of this greater trust was that the number of discrimination incident reporting forms (DIRFs) submitted by prisoners had increased substantially, by 69% since the full inspection. Training had been delivered to investigators and both the timeliness and the quality of the investigation reports had improved. A quarter of the 88 DIRFs in the last six months had been wholly or partially upheld, suggesting that the investigations were thorough and did not shy away from attributing responsibility in line with the evidence.

3.45 The Zahid Mubarek Trust had made a major contribution to improvement in 2024. Their staff were often present in the establishment, and they carried out scrutiny of all DIRF investigations. They had also delivered their ‘equality advocate’ training to several

prisoners, many of whom had moved on to other prisons with the advantage of this learning. The training programme was due to continue to make sure that advocates were skilled to support their peers.

3.46 The new governor had raised the profile of diversity and inclusion work, especially in relation to racism. She and the deputy governor had taken part in confidential 'safe space' groups with staff and prisoners about the culture of the prison. Arising from these groups, weekly forums had been established on the wings on issues relating to race and culture, to the point where they were now led by prisoners, with staff present.

3.47 Equality action plan meetings were now held every month. Members of the committee reviewed detailed analysis of outcomes relating to possible areas of discrimination, and planned actions in response. Early indications were that this was having a positive impact.

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

Care Quality Commission regulatory concerns

Regulation 10

During our 2023 inspection CQC identified one service user who received inappropriate care. Use of force footage obtained by HMI Prisons showed a service user being restrained by three prison officers in their cell on the inpatient ward. In the footage a nurse can be seen telling a service user that they need an injection (later identified as Pabrinex). On multiple occasions, the service user does give consent, but the nurse administers the medication.

During the incident, staff failed to treat the service user with dignity and respect or provide care in a caring and compassionate way when administering medication. The service user was restrained with the sole purpose of administering medication with no clear rational for doing so.

Staff failed to respect the service user's personal choice and independence. Footage of the incident showed the service user did not want the nurse to administer medication, but that this was ignored.

3.49 CQC reviewed the trust's response and spoke with management regarding this incident. Managers had reviewed the footage and had taken immediate action.

3.50 There was a new mental health workforce and managers told us that there had been a positive change in culture. Staff had a good understanding of how to provide treatment in a caring and compassionate way. We observed positive interactions between nursing staff and patients during the inspection, and were not told by patients of negative interactions with nursing staff.

3.51 The trust had re-circulated relevant policies and protocols, including the Specialist and Secured Services Directorate Refusal of Examination, Treatment or Intervention protocol; this had recently been re-ratified following minor amendments.

3.52 Staff had attended or had been booked to attend additional training sessions and lessons from incidents had been shared.

Regulation 11

As outlined in Regulation 10, during our 2023 inspection CQC identified a service user who received care without consenting. The service user was not given all the required information to make an informed decision about the proposed care. Consent was not sought and no discussion about consent took place. Footage of the incident shows consent was not implied. Records relating to the incident state the service user consented to treatment, but the footage we saw contradicted this.

The service user did not consent to treatment at any point during the administration of medicines, but this was not recognised or respected by nursing staff who continued to administer it.

3.53 Managers provided assurance to CQC, from data collected via the complaints and incident reporting system, that there had been no reported incidents of medicines being administered under restraint. Managers had re-circulated the trust's Mental Capacity Act (2005) Policy, including Deprivation of Liberty Safeguards, to all nursing staff.

3.54 Staff had attended training or were booked to attend training on the Mental Capacity Act (including Deprivation of Liberty Safeguards). Staff were required to complete this training every three years.

3.55 Staff had a good understanding of the Mental Capacity Act and there was evidence in patient records that the mental capacity of patients had been assessed and discussed at multidisciplinary meetings where it was appropriate to do so.

Mental health

Concern: Mental health services were poor. The quality and level of support for patients were very limited and did not meet the needs of the population.

3.56 Following a period of disruption, the new mental health team had been in place since February 2024. The team was effectively managed and well-led. Clinical staff were enthusiastic about meeting the needs of the patients and were working towards embedding a stepped model of care. The team comprised nurses, a psychologist and a support worker but had two vacant posts, which were being advertised.

3.57 A mental health nurse attended reception each day which meant that most new arrivals were screened promptly for any mental health needs.

3.58 Referrals were triaged each day and discussed within the team before being allocated to the most appropriate practitioner. Most patients were seen promptly, but the risk assessments and care plans were generic, and lacked the patient voice and meaningful intervention for some. Most plans had review dates.

3.59 Care plans were regularly audited and explored with practitioners during supervision. Clinical supervision and reflective practice were in place and well attended.

3.60 There were 22 patients on the care programme approach and each practitioner carried a caseload of between 10 and 20 patients, depending on the risk assessment and needs that had been identified, which was appropriate.

3.61 Interventions for patients with neurodivergent needs were too limited.

3.62 Since the last inspection, there had been a big improvement in the attendance of mental health clinicians at ACCT reviews. Clinicians told us that this was a forum in which they could identify new patients who had not been referred, and that the team was working well with the prison. We noted that incidents of self-harm were not reported in line with Trust policy, which meant that trends or contributory factors could not be identified or learned from.

3.63 Therapeutic interventions took place one-to-one but there was no support for those who posed a risk to female staff, and there were no groups to support patients with anxiety. There were no therapeutic interventions on the inpatient unit, which was a gap.

3.64 Patients awaiting transfer to hospital under the Mental Health Act were not transferred in line with national guidance. The provider took reasonable steps to transfer patients promptly, but the lack of available beds meant that some patients waited too long in an unsuitable environment.

3.65 Staff understood the Mental Capacity Act and ensured consent to treatment was obtained as appropriate. Training was ongoing to make sure newly employed and existing staff retained their knowledge and understanding. Staff treated patients with kindness, care and consideration.

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

Medicines optimisation and pharmacy services

Concern: The out-of-hours medicines cabinet was poorly stocked, contributing to delays in patients receiving medicines. There was no governance of the use of the cabinet and it contained some out-of-date medicines.

3.67 At this IRP, governance and oversight of the out-of-hours cabinet were in place; stock was regularly audited and there was an appropriate range of medicines. Prescription pads (used to obtain urgent medicines not held in the out-of-hours medicines cabinet) were stored and managed in accordance with the national requirements.

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

Care Quality Commission action plan request

During this review visit, Care Quality Commission (CQC) found two further breaches, of regulations 12 and 17, and issued requests for action plans (see Appendix III).

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: Leaders had failed to provide a curriculum that adequately prepared prisoners for employment after release and that benefited vulnerable prisoners. They did not consider local skill needs. They did not offer opportunities for accredited vocational qualifications, progress or appropriate career pathways, nor did they provide well-equipped training areas.

3.69 Leaders and managers relied on wing jobs and roles such as prisoner representatives to provide more than half the activity spaces available to prisoners. Leaders and managers had not developed a suitable curriculum for prisoners allocated to these activities.

3.70 The roles that wing workers and prisoner representatives carried out were not purposeful and did not keep them busy for the whole duration of their sessions. Prisoners did not develop the necessary workplace behaviours that would stand them in good stead upon release. For example, cleaners would rather use the wrong equipment they had been given than source the equipment that they knew they should be using.

3.71 Leaders and managers had revised their education and skills curriculum so that it now matched more closely the interests of prisoners and the local labour market needs.

3.72 Soon after the previous inspection, leaders and managers had introduced a course for prisoners to gain useful basic skills in construction, warehousing and manufacturing. Prisoners learned how to fit handles and hinges to wooden doors. A very small number of prisoners had had interviews with local employers after completing the course. More recently, leaders and managers had started teaching a health and safety in construction course as a progression route.

3.73 Leaders had considerably increased the range of courses available to vulnerable prisoners, who could now access almost the same offer as the main population. This included vocational courses, such as bike repairs, health and safety, and food safety, and personal development courses. At the time of our visit, almost all vulnerable prisoners were enrolled on activities.

3.74 Leaders and managers had commissioned courses specifically aimed at helping the young adult population overcome any behavioural and mindset barriers that prevented them from being involved in education, skills and work. Although young adults reported benefits from these courses, such as being in a better frame of mind to consider their time in prison, leaders did not capitalise on this to encourage them to take part in activities, and very few had enrolled in activities after these courses.

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

Theme 2: Leaders did not use education, skills and workplaces efficiently, allocate prisoners appropriately or secure high attendance overall.

3.76 Leaders and managers were in the process of implementing new processes to allocate prisoners to relevant activities and ensure that they attended them. The new local pay policy rewarded attending education and workshops with higher rates than wing jobs. Leaders and managers had set a requirement for prisoners to have completed assessments of their levels of English and mathematics before they could be allocated to activities or gym.

3.77 Leaders had recently introduced weekly sequencing meetings for sentenced prisoners with the aim to prioritise their allocation to suitable activities based on their current education levels and aspirations. In these meetings, prisoners met with representatives from relevant prison departments, such as activities, offender management, education and neurodiversity, to agree the best pathway for them to start working towards their short- and long-term goals. Essential information, such as prisoners' levels of English and mathematics, was not always known at the time of these meetings, which limited their effectiveness considerably.

3.78 Leaders did not have good oversight of the implementation or effectiveness of these new processes. For example, they did not know if the sequencing meetings resulted in all sentenced prisoners being allocated to activities. Leaders had not identified that the sequencing meetings partly overlapped with the work that information, advice and guidance (IAG) workers did with prisoners when setting their personal learning plans (PLPs).

3.79 Leaders' records showed that all available spaces at the time of our visit were allocated. However, leaders recognised that they needed to refine their data collection as they had identified some prisoners being allocated to multiple activities. There were prisoners who had completed courses and remained allocated to them, thus taking up spaces that others could have used.

3.80 Attendance levels were similar to those at the time of the previous inspection and were still not high enough. Over a fifth of prisoners allocated to education, skills and work activities did not regularly attend them. Attendance and punctuality at the time of our visit were particularly low.

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

Theme 3: Leaders did not provide sufficient English and mathematics spaces to accommodate the needs of the population.

3.82 Leaders and managers had doubled the number of spaces on both English and mathematics courses and now offered enough spaces for the needs of the population.

3.83 Allocation to English and mathematics courses was high. Retention and achievement had also increased and were now high.

3.84 Leaders did not monitor the English and mathematics needs of the changing prison population to adapt their offer accordingly. For example, although the need for entry level courses in mathematics was higher than in English, leaders and managers offered the same number of spaces at that level for both subjects. This resulted in prisoners waiting for entry level mathematics courses when spaces on the level 1 and level 2 course were not taken up.

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

Theme 4: Leaders did not provide effective career education information, advice and guidance. Prisoners did not receive the right advice to help them with their next steps or future careers.

3.86 Leaders and managers had now recruited to all information, advice and guidance roles. Prisoners attended initial assessment and IAG sessions more swiftly and more of these sessions routinely took place on consecutive days, resulting in prompter allocation to activities.

3.87 The number of prisoners who did not have a PLP had reduced. However, the quality of completed PLPs was variable. Often, prisoners had too many goals for a potentially short day. On other occasions, their goals did not identify their immediate needs within education, skills and work.

3.88 There was better involvement of the IAG advisors in release planning activity, but it was too early to see the impact of this.

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

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

Care and support for prisoners in their early days had deteriorated. Time out of cell was poor, first night cells were dirty and the induction was not adequately organised or informative.
Reasonable progress

Levels of violence, especially against staff, were very high. Much of this was fuelled by prisoner frustration at poor and inconsistent time out of cell and lack of response to legitimate requests through the application and complaints systems. Leaders did not deliver a full and purposeful regime that motivated prisoners to behave, engage or progress.
Insufficient progress

Care for prisoners at risk of self-harm or suicide was weak. ACCT reviews lacked a multidisciplinary approach and most were ineffective. Mental health referrals were too often overlooked.
Reasonable progress

Staff did not develop effective relationships with prisoners. Key work was not being delivered and prisoners lacked faith in the ability of staff to resolve legitimate concerns.
Insufficient progress

Many cells needed refurbishment and/or redecoration, many prisoners were held in mouldy cells, with broken windows and graffiti. Living conditions in the segregation unit were squalid**.** There was evidence of mould and infestation of rats and cockroaches.
Reasonable progress

Prisoners, staff and managers reported witnessing racism. Systems to ensure fair treatment and inclusion were weak.
Good progress

Mental health services were poor. The quality and level of support for patients were very limited and did not meet the needs of the population.
Reasonable progress

The out-of-hours medicines cabinet was poorly stocked, contributing to delays in patients receiving medicines. There was no governance of the use of the cabinet and it contained some out-of-date medicines.
Good progress

Ofsted themes

Leaders had failed to provide a curriculum that adequately prepared prisoners for employment after release and that benefited vulnerable prisoners. They did not consider local skill needs. They did not offer opportunities for accredited vocational qualifications, progress or appropriate career pathways, nor did they provide well-equipped training areas.
Insufficient progress

Leaders did not use education, skills and workplaces efficiently, allocate prisoners appropriately or secure high attendance overall.
Insufficient progress

Leaders did not provide sufficient English and mathematics spaces to accommodate the needs of the population.
Reasonable progress

Leaders did not provide effective career education information, advice and guidance. Prisoners did not receive the right advice to help them with their next steps or future careers.
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: Expectations – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)

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 [MONTH, YEAR] for further detail on the original findings (available on our website at Our reports – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)).

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:

Deborah Butler	Team leader
Ian Dickens	Inspector
Martin Kettle	Inspector
Nadia Syed	Inspector
Sarah Goodwin	Health and social care inspector
Beverley Gray	Care Quality Commission inspector
Malcolm Irons	Care Quality Commission inspector
Montserrat Perez Parent	Ofsted lead inspector
Vicki Locke	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.

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.

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

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 (UN)
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.

Appendix III Care Quality Commission action plan request

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

The review of health services at HMP Bedford was jointly undertaken by the CQC and HMI Prisons under a memorandum of understanding agreement between the agencies (see https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/working-with-partners/). The Care Quality Commission issued an action plan request following this review.

Regulation 12: Safe Care and Treatment –

1. Care and treatment must be provided in a safe way for service users.

2. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—

    a. assessing the risks to the health and safety of service users of receiving the care or treatment;

    b. doing all that is reasonably practicable to mitigate any such risks;

How the regulation was not being met

You failed to provide safe care and treatment for some patients.

- Staff did not always assess or start treatment promptly for those identified with mental health needs.

- Staff did not always provide mental health support for those who were displaying signs of mental ill health.

- Some patient care records, and risk assessments lacked detail, care plans were not personalised and did not consistently provide clarity for staff on how patients should be cared for.

- Treatment and support needs by way of intervention were not consistently documented or provided for those with identified need.

Regulation 17: Good governance 17.—

1. Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

2. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

    a. assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

    b. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

How the regulation was not being met:

- Staff had not consistently reported incidents in accordance with trust policy, During the period 01 March and 31 August 2024, 2195 self-harm incidents had occurred, some of these incidents may have occurred whilst the patient was receiving input from the healthcare team. However, none of these had been reported using the trust's internal reporting system.

- Incidents of mental health related self-harm had not been discussed at governance meetings.

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

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