Report on an unannounced inspection of

HMP Rochester

by HM Chief Inspector of Prisons

12–22 August 2024

Contents

Introduction

On the site of the UK's first borstal, and with some accommodation dating back to the late 19th century, HMP Rochester in Kent is a training and resettlement prison for up to 766 adult men. The addition of the adjacent former young offender institution, Cookham Wood, which reopened during our inspection, added a further 180 places to this now joint site. Spread across a large area and comprising several different accommodation types, the prison was marked for closure only a few years ago but had remained open largely in response to the recent prison population crisis. The underlying problems that had condemned it to closure and replacement have not, however, gone away, and the poor outcomes we observed again at this inspection compelled me to write to the Secretary of State and invoke our Urgent Notification protocol.

We have inspected Rochester on five occasions since 2013 and the prison has persistently underachieved. At this inspection, the jail attracted our lowest healthy prison assessments in three of our four tests – respect, purposeful activity and preparation for release – with many of the recommendations from our most recent 2021 inspection still to be addressed. We raised additional warnings following a disappointing independent review of progress in 2022, where we found mostly insufficient progress in addressing those recommendations.

Rochester was fundamentally failing in its rehabilitative purpose as a category C training and resettlement prison. Our checks during the working day found less than a third of the population engaged in purposeful activity and Ofsted graded the overall effectiveness of education, skills and work as inadequate, their lowest assessment. Although prisoners were generally unlocked during the day, most had nothing to do, and we observed wings that were chaotic and poorly supervised. In our survey, only 61% of prisoners said that staff treated them with respect, significantly lower than in comparable prisons. The many relatively inexperienced officers we observed lacked confidence and were not sufficiently supported to enforce basic rules and standards. A failure to deliver enough key work further reduced the opportunity to develop meaningful relationships on the wings.

Leaders were not sufficiently visible around the prison, and poor communication had led to inconsistent standards and inconsistent provision across the jail. Security controls on the movement of prisoners were not proportionate for the type of prison, imposing escorting arrangements to activities and appointments that caused considerable delays and frustration. It often took so long to move around the jail that prisoners chose not to go to work in case they missed meals or medical appointments.

Safety was also deteriorating. Reported incidents of violence against staff and prisoners had increased; for example, the rate of prisoner assaults had increased by 67% in the past year. Behaviour management systems were ineffective, and in our survey, only 15% of respondents felt that the culture of the prison encouraged them to behave. Use of force was high, and we identified some that was inappropriate. There had been two self-inflicted deaths since our

last inspection and there were more reported incidents of self-harm. Illicit drug use was endemic; the rate of positive random mandatory drug tests was the third highest of all category C prisons at 42%. In our survey, over half of all prisoners said it was easy to get alcohol and drugs, including other prisoners' diverted medications.

Accommodation across the prison was mixed but much remained dilapidated, with some of the worst conditions we have seen in recent years. Staff and prisoners told us that rats and mice regularly entered cells and offices on the older wings. Prisoners resorted to creating barriers from cardboard or towels to fill gaps under cell doors to keep vermin out. The grounds were better but drab. The offender management unit was ineffective and critically short of trained probation staff to manage high-risk prisoners. Added to this, public protection arrangements were not fit for purpose. Prisoners told us of their frustrations at the lack of contact with offender managers, and how they struggled to progress in their sentence because of insufficient risk reduction work.

We identified some very poor outcomes in health care. Medicine administration and supply arrangements were inadequate, and patients missed or faced delays in receiving some important medicines. Internal and external clinical appointments were cancelled too frequently; this meant care and treatment could be hampered, leading to clinical risk and complication. These issues were a significant concern to the Care Quality Commission as the health care regulator.

During the inspection we were reassured that the prison group director was aware of the many problems at this prison. The recent appointment of an interim governor was an important start in the process of revitalising a moribund institution. An additional challenge for leaders, however, was the reopening and merger between Rochester and the adjacent Cookham Wood. During the week of our inspection prisoners had begun transferring to Cookham Wood, although the plans for how the arrangement would be handled in future seemed limited. There was a risk that this would be a distraction from the very pressing problems at Rochester.

Continued support from senior leaders and substantial investment by HM Prison and Probation Service will be necessary if both prisons are to operate effectively, provide decent living conditions and become purposeful, rehabilitative places.

Charlie Taylor
HM Chief Inspector of Prisons
October 2024

What needs to improve at HMP Rochester

During this inspection we identified 13 key concerns, of which seven should be treated as priorities. Priority concerns are those that are most important to improving outcomes for prisoners. They require immediate attention by leaders and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

1. **Levels of safety in the prison was deteriorating, and both violence and self-harm were increasing.** The safety strategy was out of date, not well informed by data and lacked an action plan.

2. **Many cells and communal facilities were in a very poor state of repair, were vermin-infested and required substantial investment.**

3. **Rochester was failing in its function as a training and resettlement prison.** There were insufficient spaces in education, skills and work to meet the needs of the prison population, and too few prisoners were able to attend.

4. **The availability and use of illicit drugs posed a major threat to safety and security.** The positive drug testing rate was among the highest for this type of prison.

5. **Clinical practice and poor oversight were allowing health care provision that was unsafe, ineffective and inefficient.** For example, patients waited too long to be seen by a GP and both internal and external clinics were routinely cancelled.

6. **The offender management unit (OMU) was critically under-resourced and unable to deliver its core functions.** There were weaknesses in public protection and risk management work, and insufficient contact between prison offender managers and prisoners, limiting support for sentence progression.

7. **The high number of inexperienced officers did not always enforce standards of good behaviour among prisoners. Leaders were not sufficiently visible, and staff lacked support.**

Key concerns

8. **Use of force was high, and oversight and accountability were lacking.**

9. **Work to ensure fair treatment and inclusion was inadequate.** Prison data had indicated disproportionate outcomes for prisoners in some

protected groups, and Muslim prisoners reported more negative experiences.

10. **Medicine administration and supply arrangements were poorly managed and took too long. Supervision was limited and there was no patient privacy.** Expected administration times were not being adhered to, and patients missed or faced delays in receiving important medicines.

11. **Leaders had been too slow to implement a prison-wide reading strategy.** Reading was not promoted sufficiently across the prison and too many prisoners did not receive appropriate support to develop their skills**.**

12. **Not enough enrichment activities were provided.**

13. **The vast majority of prisoners did not benefit from access to high quality education, skills and work.** The prison's quality improvement group, and its associated planning to address weaknesses, were ineffective at driving change.

About HMP Rochester

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

Certified normal accommodation and operational capacity (see Glossary) as reported by the prison during the inspection

Prisoners held at the time of inspection:
Rochester – 761
Cookham Wood – 10

Baseline certified normal capacity:
Rochester (baseline CNA is 862, but C wing has been closed for many years) 766
Cookham Wood – 193

In-use certified normal capacity:
Rochester – 759
Cookham Wood – 193

Operational capacity:
Rochester – 766
Cookham Wood – 70

Population of the prison
- Approximately 110 new receptions each month.
- 4% foreign national prisoners.
- 21% of prisoners from black and minority ethnic backgrounds.
- Approximately 66 prisoners released into the community each month.
- 298 prisoners currently receiving support for substance misuse.
- 90 prisoners referred for mental health assessment each month.

Prison status and key providers
Public

Physical health provider: Oxleas NHS Foundation Trust
Mental health provider: Oxleas NHS Foundation Trust
Substance misuse treatment provider: Change Grow Live (CGL)
Prison education framework provider: Milton Keynes College
Escort contractor: Serco

Prison group/Department
Kent, Surrey and Sussex

Brief history
Rochester Prison, which was originally established in 1874 on a former military site overlooking the Medway River, has undergone several transformations. It was converted into a youth custody centre in 1983 and became a remand

centre for Kent courts in 1988. In 2011, it was re-designated as a dual-purpose facility for young adult and adult category C prisoners.

Currently, HMP Rochester accommodates 766 prisoners in a range of accommodation, from the original wings built in 1874 to four modern units constructed in 2007-8, along with 60 rapid deployment cells which opened in January 2024.

HMP Cookham Wood has recently been reclassified as a male category C prison operating as part of HMP Rochester and will accommodate up to 70 prisoners until necessary refurbishments are completed.

Short description of residential units

A wing: Drug recovery unit.
Original buildings date from 1874.
Capacity: 79

B, D, E wing: General population
Original buildings date from 1874.
Capacity: 101, 100, 120

R wing: First night and induction
Constructed in 2007-8. All cells are en suite.
Capacity: 60

F, G wing: General population
Constructed in 2007-8. All cells are en suite.
Capacity: 60, 60

H wing: Incentivised substance free living (ISFL)
Constructed in 2007-8. All cells are en suite.
Capacity: 126

I wing: Enhanced prisoners
Rapid deployment en suite cells.
Capacity: 60

J wing: Cookham Wood
All cells are en suite.
Capacity: 90

K wing: Cookham Wood
All cells are en suite.
Capacity: 86

L wing: Cookham Wood
All cells are en suite.
Capacity: 17

Name of governor/director and date in post
Katie Jefferson (interim governor), April 2024

Changes of governor/director since the last inspection
Dean Gardiner, October 2018 – April 2024

Prison Group Director
James Lucas

Independent Monitoring Board chair
Susan Fitzjohn

Date of last inspection
4 and 11–15 October 2021

Section 1 Summary of key findings

Outcomes for prisoners

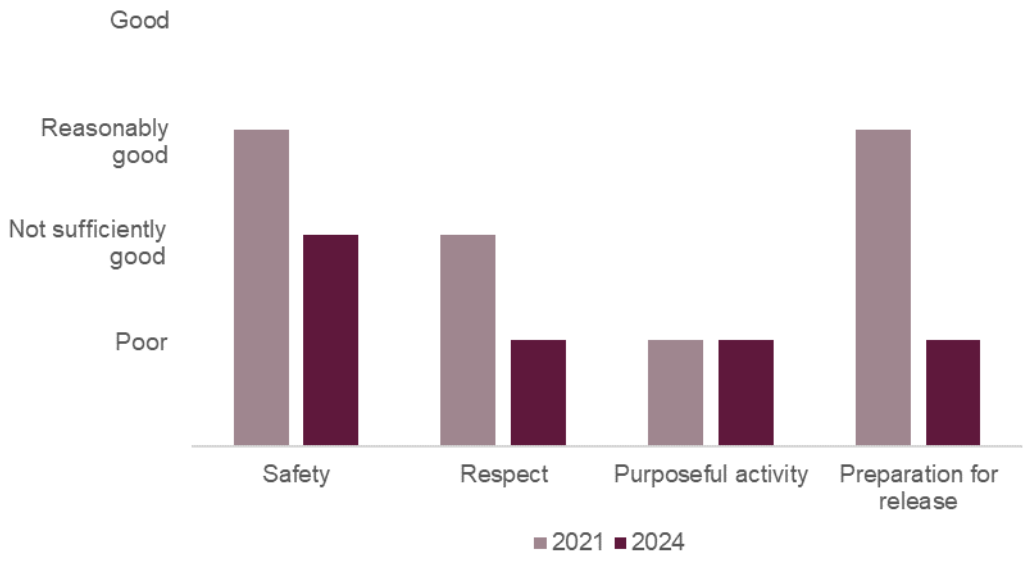
1.1 We assess outcomes for prisoners against four healthy prison tests: safety, respect, purposeful activity, and preparation for release (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.2 At this inspection of HMP Rochester, we found that outcomes for prisoners were:

- Not sufficiently good for safety
- Poor for respect
- Poor for purposeful activity
- Poor for preparation for release.

1.3 We last inspected HMP Rochester in 2021. Figure 1 shows how outcomes for prisoners have changed since the last inspection.

Figure 2: HMP Rochester healthy prison outcomes 2021 and 2024



Progress on key concerns and recommendations

1.4 At our last inspection in 2021 we made 30 recommendations, eight of which were about areas of key concern. The prison fully accepted 24 of the recommendations and partially (or subject to resources) accepted six. It rejected none of the recommendations.

1.5 At this inspection we found that one of our recommendations about areas of key concern had been achieved, three had been partially achieved and four had not been achieved. The only recommendation achieved was in the area of respect, with those recommendations in safety and purposeful activity either partially or not achieved. For a full

list of the progress against the recommendations, please see Section 7.

Notable positive practice

1.6 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.

1.7 Inspectors found one example of notable positive practice during this inspection, 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)	Automated dispensing was used to make labelled 'pill pouches' to aid the administration of single dose medicines required to be taken in the evening. The pharmacy team had also sourced a braille multi-compartment compliance pack for a patient so that they could manage their own medicines in-possession.	See paragraph 4.73

Section 2 Leadership

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

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

2.2 Leaders had still not addressed most of the concerns raised at our last inspection, and outcomes in many important areas had deteriorated. The prison was more unsafe, illicit drug use was widespread, and our checks found less than a third of the population engaged in purposeful activity.

2.3 The new interim governor, appointed four months before we arrived, had begun the process of assessing the challenges and identifying priorities, but was still in the early stages of developing plans for improvement.

2.4 Leaders were not sufficiently visible, and poor communication had led to inconsistency in delivery across the whole prison. The interim governor had identified the need to promote more cohesive and supportive working among the senior team, and to drive greater accountability from managers.

2.5 Although the prison had now recruited its full complement of Band 3 officers, around half had been in post for less than a year and almost three-quarters for under two years. Some officers told us that they had not felt well supported in their new role, and we found very limited managerial presence providing supervision on wings at key times. Rates of staff attrition and sickness absence were high. Leaders told us they were exploring ways of improving staff engagement. The interim governor had also prioritised addressing the negative staff culture and had, for example, begun delivery of training to build capability.

2.6 Security controls on movement of prisoners were not proportionate to the type of prison. Escort arrangements to activities and appointments were causing delays and frustration which totally undermined the prison's core training function. Leaders had plans to reintroduce 'free flow' imminently, which would allow prisoners to move around the prison without always requiring an officer to escort them.

2.7 The offender management unit (OMU) was ineffective and critically short of trained probation staff to manage high-risk prisoners. Public protection arrangements were not fit for purpose. Prisoners told us of their frustrations at the lack of contact with offender managers, and how they struggled to progress in their sentence because of insufficient risk

reduction work and purposeful activity. Key work was also far too limited and did not support offender management.

2.8 Behaviour management systems were ineffective, and leaders had not introduced meaningful incentives to promote positive behaviour by, for example, using the variety of wings to motivate prisoners, or develop a clear pathway for progression. Work to promote fair treatment had also been neglected.

2.9 Leadership of education, skills and work was graded as inadequate by Ofsted. The prison's quality improvement group for education skills and work and its associated planning to address weaknesses had been ineffective in driving change.

2.10 While partnership working between the prison and the health care provider was improving, we identified some very poor patient outcomes which were a significant concern to the Care Quality Commission (CQC) as the regulator of health care. Medicine administration and supply arrangements were inadequate, and internal and external clinical appointments were cancelled too frequently.

2.11 Efforts to refurbish cells with the assistance of skilled prisoners were encouraging, but much of the accommodation remained dilapidated, infested with vermin and in need of substantial investment. Leaders had introduced a system for regular accommodation decency checks, but these were not robust.

2.12 Although some prisoners had begun transferring to the re-opened HMP Cookham Wood during the week of our inspection, plans to merge the two prisons were not well developed. There was a potential risk that this additional challenge would be a distraction from the very pressing problems at the Rochester site.

2.13 The prison group director was aware of the many problems at this prison. His continued support and considerable investment by HM Prison and Probation Service (HMPPS) will be necessary for both prisons to operate effectively and fulfil their rehabilitative purpose.

Section 3 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

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

3.1 Rochester received an average of 21 new arrivals a week, almost all from nearby prisons. At the time of the inspection, there were more prisoners arriving than usual – up to 12 a day – but we observed that reception processes were still completed courteously and promptly.

3.2 In our survey, only 36% said they spent less than two hours in reception, which was similar to other category C prisons. We observed waits of around two hours, with staff taking new arrivals over to the induction wing in groups once they had completed reception processes to minimise waiting times and to prevent the holding room getting too crowded.

3.3 There was one main holding room, an austere environment with some basic information on display about the core day and mental health services available at the prison, and a toilet that lacked sufficient privacy. A second, much smaller, windowless holding room was rarely used.

3.4 It was positive that prisoners received a lunch pack in reception, regardless of their time of arrival, as well as a hot evening meal once they got to the induction wing.

Holding room

Lunch packs

3.5 First night safety interviews were not sufficiently private which could disincentivise prisoners from disclosing their risks and vulnerabilities. The interviews were held in a small office next to the main reception area with the door wedged open. We also observed that electronic records of these interviews did not always include pertinent information for officers on the induction wing to support these prisoners in their

early days. For example, information was not recorded about a foreign national prisoner struggling to understand English or for another prisoner arriving with an eye injury.

3.6 Peer supporters were under-used on the first night. Although new arrivals were briefly introduced to a Listener (prisoners trained by the Samaritans to provide emotional support to other prisoners) and an induction orderly, they did not have the opportunity for a confidential or meaningful conversation.

3.7 First night cells were generally clean, appropriately equipped and had in-cell showers and phones. In our survey, prisoners reported more positively than at similar prisons about getting toiletries, a phone call and vapes on their first night.

3.8 Staff conducted three additional welfare checks on new arrivals throughout their first night, which was an effective way of ensuring the well-being of individuals and for recording any concerns.

3.9 Induction began at 8am the following morning, with a presentation delivered by two induction orderlies which gave a reasonably good introduction to life at Rochester. However, prisoners often waited up to two weeks to see a member of staff from education and the offender management unit (OMU), which was a source of frustration for many.

3.10 Prisoners had to wait up to nine days to be able to buy and receive items from the canteen, which was too long. To mitigate this, the prison offered an advance of up to £15 that prisoners could spend on basic grocery items or vapes in reception. However, this was not always enough, and the sum was recovered in full as soon as the prisoner had money in their account and was, therefore, counterproductive in preventing prisoners getting into debt. After we raised this concern during the inspection, leaders agreed to recover the advance over three weeks instead.

Promoting positive behaviour

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

Encouraging positive behaviour

3.11 Levels of violence against staff and prisoners had increased significantly since our last inspection. Over the last 12 months, assaults against prisoners had increased by 67% and against staff by almost half. Serious assaults against prisoners had similarly increased, and the overall levels of violence were higher than the average for category C prisons. In our survey, 42% of respondents said that they had felt unsafe at some point, compared to 27% at the time of the last inspection.

3.12 Despite this increase in violence, the safety strategy and accompanying action plans made little use of data and strategies were consequently too generic. A comprehensive safety summit had, however, recently taken place to try to improve understanding of the reasons behind increased violence, but this had not yet been translated into actions.

3.13 Leaders understood that safety was a priority, and that violence needed to be robustly challenged. However, processes to manage violence within the prison were applied inconsistently and were having little impact. Work to support both victims and perpetrators of violence was weak. Challenge, support and intervention plans (see Glossary) were not always opened when they should have been, and targets were often not specific to the individual when they were. We also saw evidence of low-level poor behaviour going unchallenged by staff (see paragraph 4.3).

3.14 The safety team was inadequately resourced with only one safety officer who was routinely redeployed. This limited the ability of the team to undertake crucial work in areas such as debt reduction and engaging with young adults, who were disproportionately involved in violence (see paragraph 4.29.).

3.15 The policy for a revised incentive scheme was still in draft form, and prisoners told us that they felt the existing scheme was used unfairly. We found examples of prisoners who were unaware that they had been issued warnings. The regime for men on the lowest incentive level varied between units, and prisoners told us that they had not been invited to participate in reviews.

3.16 In our survey, only 15% of prisoners felt that the culture of the prison encouraged them to behave, compared with 26% in similar prisons. Only I wing appeared to us to offer anything like an incentivised regime for those who lived there (see paragraph 4.12). Prisoners on the unit spoke of living as a community, with shared cooking facilities and a more acceptable environment. However, many prisoners on other units did not feel that moving to I wing was achievable. Prisoners told us that, rather than the newer accommodation being incentivised, a move to the poorer conditions of the older accommodation was more likely to be used as a threat or punishment.

Adjudications

3.17 Since our last inspection adjudications had increased by 38% and were now higher than similar prisons. There had been 2,685 adjudication hearings in the last year, most of which were for unauthorised articles, fights or assaults, which reflected the increase of violence and drugs within the establishment.

3.18 There was a backlog of 138 adjudications, which the prison was struggling to reduce. In the sample of adjudications we reviewed, we found that hearings lacked enquiry. We found some awards which were not in line with published tariffs and there was no explanation as to why

awards had varied. Although the deputy governor quality assured adjudications and identified the same issues that we found, this had not yet driven improvements in the overall quality.

3.19 Too many prisoners were placed on report for matters that could perhaps have been dealt with through the incentive scheme. This was in part due to a lack of confidence by the wing staff in the other behaviour management processes, but also too few officers trained in adjudication procedures. Adjudication data was monitored at meetings, but little action had been taken to make improvements.

Use of force

3.20 Use of force incidents had increased by half since the last inspection and the rate was now higher than the average for similar prisons, but most instances were comparatively low level.

3.21 There had, however, been seven incidents of batons being drawn although not used, two cases of PAVA (see Glossary) being drawn, and one incident where PAVA was deployed. All these incidents had been reviewed, but we found those involving the drawing and use of PAVA were inappropriate. In one instance, for example, PAVA was drawn pre-emptively as part of a planned use of force, which was unacceptable.

3.22 Debriefs were conducted with prisoners after force had been used, but these were perfunctory and provided little insight.

3.23 Governance and oversight had recently been reviewed, with increased attendance at a weekly scrutiny meeting. The prison now reviewed all incidents of force in these meetings. However, our review of video footage and documentation found issues with some incidents that had not been identified by the prison. This included some use of force that was not proportionate or necessary.

3.24 There was no strategy to reduce the use of force and learning that had been identified by scrutiny meetings was not widely shared. Leaders held monthly use of force meetings to review data and trends, but there was no plan to drive improvement (see paragraph 4.26). It was concerning that the prison had identified disproportionate force used against black and minority ethnic prisoners but had failed to examine this further or take any action.

3.25 Health care staff did not always complete necessary checks following an incident of force. This meant that prisoners' injuries were not being picked up promptly, if at all.

3.26 Unfurnished accommodation had been used three times in the last year. From the documentation we reviewed all instances were appropriate, and these extreme conditions were used for the shortest time possible. For example, we found one man who was held for less than 10 minutes before being moved back to his cell.

Segregation

3.27 Segregation had been used 500 times in the last year, which was similar to the last inspection. The segregation unit was rarely full, and the average length of stay was slightly lower than we usually see.

3.28 Prisoners were also regularly segregated on the wings, pending adjudication, usually without appropriate authorisation or safeguards. We spoke to prisoners who had been kept locked for over 72 hours without any of the correct processes for segregation being followed.

3.29 The standard of documentation in the segregation unit was poor, which meant it was not always clear when and why prisoners had been segregated. The quality of reintegration plans was also inadequate. During our visit, nine of the 10 prisoners on the unit were either awaiting a transfer to another jail or refusing to return to the wings.

3.30 The unit was clean and well ordered, but the exercise yards remained bleak and had not improved since the last inspection. The unit had recently had in-cell telephony installed which was positive, and prisoners were offered a full hour of exercise each day. However, the regime still remained too limited, with only the librarian visiting the unit to offer any activity.

Segregation unit

3.31 We observed positive staff/prisoner interactions on the unit, and prisoners spoke highly of how staff treated them. Staff understood the needs of the individuals on the unit, and we observed some good work with challenging prisoners to encourage them to participate in the albeit limited regime.

Security

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

3.32 Security arrangements were restrictive for a category C prison of this type. There was no 'free flow' of prisoners to activities or indeed any other free movement around the prison, with the exception of a few trusted prisoners, and even they expressed frustrations at the difficulty in getting around. There was also an early evening curfew in place for those prisoners living on I wing (see paragraph 4.12), despite prisoners having been risk assessed as suitable for the relatively open environment.

3.33 The monthly security committee reviewed a wide range of intelligence and other data to identify current and emerging risks to the safety and security of the prison. These risks were routinely identified as the ingress of drugs, mobile phones and other contraband, as well as violence. The risk of escape had recently been added to this list following repeated failures to secure gates and doors across the prison. Monthly security objectives were identified, but they were pitched at a strategic level and were not broken down into specific actions for staff.

3.34 It was disappointing that many of the actions identified from intelligence were not followed up. For example, only four out of a requested 166 suspicion drug tests were completed during the six months prior to our inspection, and only around half of 'priority searches' were undertaken. This was often due to the redeployment of security staff to other general duties. The success rate when searching did take place was over 40%, with finds consistent with the intelligence picture in relation to drugs, phones and weapons.

3.35 In our survey, over half of all respondents said that it was easy to get alcohol and drugs, including other people's medications, at the prison (alcohol 53%, drugs 58%, other people's medication 57%). This was borne out by the high mandatory drug testing failure rate which, at 42%, was the third highest for category C prisons and the fifth highest for prisons overall. The drug treatment wing had the highest rate of prisoners found under the influence, accounting for almost a quarter of incidents in the previous six months, with the incentivised substance free living (ISFL) unit being the second highest.

3.36 The drug strategy was too generic and not specific to the needs of the prison. Leaders were reviewing the strategy with a view to making it more reflective of the issues at Rochester and how they would be tackled.

3.37 Links with the police remained good, and police intelligence officers worked with the security team sharing information. Inter-agency work took place to try to manage organised crime gangs and attempt to identify and tackle staff corruption.

Safeguarding

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

Suicide and self-harm prevention

3.38 There had been two self-inflicted deaths since the last inspection, one in 2022, the second in 2024. Prisons and Probation Ombudsman recommendations relating to these, and previous self-inflicted deaths had been implemented swiftly, but there was no effective process to monitor whether the learning was being sustained.

3.39 Rates of recorded self-harm had increased by 79% since the last inspection and were now around average for a category C prison. However, few incidents were classified as serious, and one near-fatal incident was investigated well, and appropriate safeguards put in place to support that prisoner.

3.40 Despite levels of self-harm rising consistently over the past 18 months, leaders had been slow to act in response. While there had been some good, thoughtful, and multidisciplinary work with a handful of men who were the most prolific self-harmers, leaders had not been using data well to understand patterns of self-harm across the prison. There was no coordinated action plan to bring together key departments to tackle the underlying prison-wide issues, such as substance misuse and a lack of purposeful activity, and to reduce self-harm.

3.41 Prisoners supported by assessment, care in custody and teamwork (ACCT) case management told us they did not feel cared for by staff. Many were frustrated that their underlying issues which led them to self-harm – for example being under threat from other prisoners, their in-cell phone being broken, or not getting their medication at an appropriate time – were not being addressed.

3.42 It was disappointing to see that those in the most acute need – prisoners in crisis and deemed to require constant supervision by staff to prevent them harming themselves – were left locked in cells and observed through a cell door, rather than being unlocked to associate with peers.

3.43 However, some plans for improvement were in the early stages of development at the time of the inspection. Following consultation with staff and prisoners at the recent ‘safety summit’ (see paragraph 3.12),

leaders now had a good understanding of the drivers of self-harm, including drugs and associated debt, frustrations with inconsistent treatment and a lack of purposeful activity. A new safety strategy and action plan was being written which would specifically target these issues.

3.44 Leaders were also preparing training sessions for staff, after identifying weaknesses in their knowledge and skills, to help improve the support they provide to prisoners. For example, leaders had recognised that staff did not always identify prisoners' risks and triggers related to self-harm or use them to formulate appropriate care plans.

3.45 Officers lacked awareness of the Listeners scheme, and we were told that requests to speak to a Listener were not always facilitated as a result. In addition, the prison lacked appropriate confidential spaces for prisoners to speak to Listeners; most were in double cells which would not have given any privacy, and appropriate office space was extremely limited on wings.

Protection of adults at risk (see Glossary)

3.46 There was no local safeguarding strategy to protect adults at risk, although many staff we spoke to were aware of how to recognise signs of harm or vulnerability and said that they would raise any concerns with a manager. We saw evidence that potentially vulnerable prisoners had been discussed at the weekly multidisciplinary safety intervention meeting as a result of such referrals. However, we also found that some prisoners with social care needs were not having their needs met (see paragraphs 4.55 and 4.56).

3.47 Links with the local authority adult safeguarding board were weak; a regional representative attended meetings, but prison leaders could not demonstrate what information had been shared with them. Leaders were working to address weaknesses in this area; a new safeguarding memorandum of understanding between the prison, the health care provider and the local authority had recently come into force, and a new safeguarding lead had been recruited but had not yet started work.

Section 4 Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

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

4.1 In our survey, fewer respondents than at similar prisons said that staff treated them with respect (61% compared to 76%). In addition, 46% said they had been bullied or victimised and 35% said they had received verbal abuse from staff, both of which were also worse than at similar prisons.

4.2 Many staff were new and inexperienced (see paragraph 2.5), which had contributed to inconsistent treatment of prisoners. While we observed some positive and caring interactions, many men told us that the inability of officers to answer even basic questions was frustrating. Prisoners also reported that some staff could be unhelpful, rude or dismissive.

4.3 Many officers lacked confidence in enforcing basic rules and standards (see paragraph 3.13). We observed several instances of poor prisoner behaviour going unchallenged such as vaping on wings and very loud music being played. Officers were not visible on landings, with some routinely locking themselves away in wing offices. Furthermore, frontline managers also lacked visibility and failed to provide sufficient support to officers. In our survey, only 19% of prisoners said they could talk to managers, which was lower than at similar prisons.

4.4 Electronic case notes showed that only around 3% of expected key work sessions had been delivered in the six months before our inspection. Leaders had prioritised a small cohort of prisoners to receive a session to improve safety and reduce violence. However, very few benefited from having a regular key worker and delivery was poor. In our survey, 64% of respondents said that they had a named officer, and only 49% said they found them helpful, which was worse than similar prisons.

4.5 The use of peer workers was under-developed with very few existing roles to encourage ‘active citizenship’ within the prison community.

Daily life

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

Living conditions

4.6 On the older wings, built in the 1800s, managers, staff and prisoners told us, and we observed, frequent failures of the electrical system, damaged flooring and leaking sinks and toilets. These units had been previously identified for closure but remained open following population pressures across the prison estate.

4.7 Vermin was ever present, with rats and mice in the grounds around waste bins and evidence of rat and mouse droppings inside the residential areas. Many areas, including staff offices, had to be cleaned and sanitised each morning before they could be used, and the smell of rat urine in some areas was overpowering. Throughout the inspection both staff and prisoners complained about the infestation. Staff showed us where the rats had come in through ducting and around pipes. It was evident that mice were also commonplace, and on some wings nearly all prisoners put makeshift barriers beneath their cell doors to try to keep rodents out.

Rodent barriers

4.8 Many cell windows across the prison needed repair as vents did not work. This, coupled with the painting over or blocking of cell ventilation panels, made it impossible to regulate the temperature inside. Not all cell toilets were screened, leaving them in full view from observation panels. Timeliness of repairs by the on-site maintenance team had improved, but others involving external contractors took longer. Prisoner work parties had recently been introduced to supplement

minor work, such as deep cleaning, painting cells and repairing furniture.

4.9 Although most prisoners said they could get cleaning materials from staff, too many chose not to, and on some of the older wings, staff failed to ensure even a basic cleaning regime. The prison had introduced a 'decency programme', designed to improve standards and hold staff and managers accountable, but this was not robust. We still found some cells to be squalid, cluttered and to contain offensive graffiti. Some cells had been painted in dark colours by cell occupants which further added to the dreariness of accommodation. The prison's own data showed a failure to routinely maintain accommodation checks.

External areas (top left), E wing landing (top right), A wing sluice (bottom left) and shower room ceiling (bottom right).

4.10 External areas of the prison were cleaner and reasonably well maintained, although drab. Some internal communal areas across the prison were maintained to a better standard, for example on E wing, but we observed showers and sluice rooms that were dirty and had not been cleaned for some time. Shower areas had been refurbished in recent years and were accessible to all during the day and early evening.

In cell graffiti

4.11 The newer accommodation (F, G, R and H built in 2007) at the 'lower site' provided better equipped cells which included in-cell showers, and most cells were adequately maintained. A few cells had been doubled and we considered there to be too little room and furniture for two. A failure to maintain guttering on roofs was leading to some water damage and algae on some external walls.

Birds' nest (left) and dirty wall

4.12 The 60 excellent accommodation pods and facilities that made up the recently opened I wing offered the best living conditions. They consisted of a decent size living/sleeping area and a separate bathroom. Prisoners were not locked in and enjoyed access to a good range of recreational areas and an impressive self-cook facility. Although prisoners were risk-assessed before being allowed to live on I wing, an early evening curfew of 6.15pm meant that prisoners had to return to their rooms until 'unlock' the next morning (see paragraph 3.32).

4.13 Access to stored property had much improved since our last inspection and requests, if approved, were fulfilled within a few days.

4.14 Most men chose to wear their own clothes. These could be laundered weekly at the well-run central laundry. Apart from A wing, which still had its own laundry, each wing had allocated times during the week, and it was usual to receive laundry back in just a few hours. Prison clothing was available for those who required it and could be exchanged weekly.

4.15 A few prisoners moved to the nearby Cookham site during our inspection (see paragraph 2.12). Cells there were among the best that we see across all prisons. The accommodation units had been redecorated, and refitted where necessary, to a high standard. Communal areas were bright, open, and furnished with comfortable seating and communal dining areas.

Cookham Wood accommodation area

Residential services

4.16 In our survey, just a third of prisoners reported that the quality of food was very/quite good and that they got enough to eat, although this was similar to other prisons we had inspected recently. We observed poor supervision of serveries by officers which meant that meal options often ran out before the end of the meal service. Prisoners told us they risked missing out on meals because they were often served before they arrived back from activities, thereby disincentivising attendance at education, training and work.

4.17 Menus catered for a range of dietary requirements, including for those with allergies. A cold meal was provided for lunch, and a hot dinner from 4.15pm, although this was too early. The following day's meagre portion of breakfast cereal was also handed out with lunch, and milk was distributed at dinner. Each week prisoners were given a 'tea pack'

consisting of tea bags, milk powder and sugar, but staff and prisoners told us the quantity in the pack varied and seldom lasted the week.

4.18 Prisoners were able to dine communally, but self-catering facilities were limited to microwave ovens and toasters. However, there were better facilities on the incentivised substance free living (ISFL) unit and excellent facilities on I wing. Although servery workers were not all trained in basic food hygiene, food preparation areas that we observed were kept clean.

I wing self-cook facilities

4.19 The kitchen employed around 16 prisoners who received basic training in food hygiene, but no accreditation or other skills development was available.

4.20 The prison shop list had a reasonable range of products, including fresh fruit and vegetables. Shop orders were delivered on a weekly basis; however, some items were regularly out of stock, and delays with issuing a refund had caused frustration among prisoners. Leaders had held a prisoner forum with the shop provider to resolve the problem and there were early indications of an improvement.

Prisoner consultation, applications and redress

4.21 Arrangements for consultation with prisoners were in place. The head of residence held monthly 'prisoner voice meetings', giving prisoners the opportunity to raise issues or concerns. Minutes of the meetings recorded wide-ranging and useful discussions, but not all wings were represented each month. Actions raised at these meetings were followed up quickly, and there were good examples of resolution, such as improvements to the prison shop refunds process. However, most

prisoners were unaware of the meeting, and only 32% of those responding to our survey said that they were consulted about issues affecting them, which was lower than the comparator.

4.22 The applications process was poor and, in our survey, only 19% of respondents said that they received application replies within a week, which was worse than in similar prisons. Applications were paper based and were still not logged or monitored. There was also no quality assurance of the process on most wings.

4.23 Leaders had introduced a trial on A and H wings to improve the process, but prisoners responsible for dealing with the applications said they had not been given any training and replies were still not logged.

4.24 The complaints process was better, with prison data showing around 91% answered within the required timescale. Replies were generally polite and addressed the complaint well. However, prisoners' trust in the system was low. In our survey, only 17% said they were dealt with fairly and only 10% said they were responded to within seven days, which was lower than elsewhere.

4.25 Provision for prisoners to meet their legal representatives was insufficient. There was only one room available for video calling and one for face-to-face visits during weekday mornings. The next available slot was almost five weeks away. In our survey, only 32% of prisoners said they could communicate with their solicitor or legal representative and only 27% said they could attend legal visits, which was worse than in similar prisons.

Fair treatment and inclusion

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

4.26 Work to promote fair treatment and inclusion had not been prioritised, and support for prisoners with protected characteristics was limited. The diversity and inclusion team were under-resourced; the lead manager was also responsible for other key areas in the prison such as safety, and the equalities officer was often cross deployed to work on residential wings due to staff shortages. There had only been two equality meetings in the previous 12 months, and the action plan to drive improvement was not yet fully developed.

4.27 Prison data had indicated disproportionate outcomes for prisoners in some protected groups, particularly in areas of discipline, including use of force and adjudications (see paragraph 3.24). Most Gypsy, Roma and Traveller prisoners we spoke with felt they were being

discriminated against or that others received preferential treatment, which created tensions. There had been limited work to explore these sensitive issues.

4.28 In our survey, Muslim prisoners reported more negative experiences; only 28% said that staff treated them with respect compared to 66% for non-Muslim prisoners. And just a third felt their religious beliefs were respected compared to 72% for non-Muslims. Prisoners and staff told us about problems with arrangements for Friday prayers, which had led some prisoners to decide not to attend; not all men had the opportunity to shower beforehand; they were sometimes searched by prison dogs on arrival, which they considered to be unhygienic; and regular testing of the fire alarm caused disruption to the service. Furthermore, the risk assessment for the multi-faith room indicated that it could not always accommodate all Muslim prisoners who wished to attend. As a result, the service occasionally took place in the sports hall, which lacked ablution facilities and was an inappropriate place for prayer.

4.29 Although 15% of the population were aged 25 or under and were involved in a disproportionate number of violent incidents (cross ref safety), engagement and support for this group was very limited. There was no young adult's strategy.

4.30 The small number of prisoners with disabilities received inadequate care; we found some physically challenged and disabled prisoners living in poor conditions with no adaptations and very limited support (see paragraph 4.56). Personal emergency evacuation plans lacked detail, and not all staff we spoke with were aware of the plans.

4.31 Senior leaders were allocated as leads for each of the protected characteristic groups, but consultation to understand prisoners' experience, and to address any ongoing issues or concerns had been too infrequent. However, support for older prisoners and veterans was marginally better and it was positive that the Care after Combat veterans' charity had regularly visited the prison.

4.32 More positively, a neurodiversity support manager had been appointed and prisoners we spoke with were very positive about the support they had received. Sensory aid and distraction packs had been provided to prisoners to help them manage anxiety and reduce the impact of their neurodiverse conditions. There was also a weekly LEGO therapy session to develop social skills in a group setting, available to a small number of prisoners. The support lead was integrated well into the prison and had organised a family day for 14 neurodivergent prisoners, and a pre-release event which was attended by 35 prisoners, involving various agencies and charities to support prisoners on release (see paragraph 6.5).

4.33 Investigations into discrimination complaints were reasonable and most involved a discussion with the prisoner raising the concern. However, quality assurance was inconsistent, there was no independent scrutiny and prisoners lacked confidence in the process.

Faith and religion

4.34 Support for faith and religion was very good. The chaplaincy team were visible and effectively engaged in many aspects of prison life, including visiting those supported by assessment, care in custody and teamwork (ACCT) case management each week and attending reviews when required. In our survey, more respondents than in similar prisons said they had spoken to a member of the chaplaincy team (80% versus 70%).

4.35 The chapel was welcoming, with good facilities for religious services and there was a multi-faith room with ablution facilities. However, Muslim prisoners reported negative experiences with the prison's arrangements for Friday prayers (see paragraph 4.28).

Chapel

4.36 Alongside extensive pastoral support, the chaplaincy delivered a programme of communal worship sessions, study groups, Sycamore Tree (a community volunteer-led victim awareness programme) (see paragraph 6.32), a 'living with loss' course and a programme to connect dads to their children while in prison and prepare for fatherhood on release called InsideOut Dads.

4.37 Chaplains also supported prisoners to maintain links with the outside world. For those who did not receive social visits, the Official Prison Visiting Scheme was available (see paragraph 6.6). Volunteers from outside faith organisations also offered support to those returning to the community.

Health, well-being and social care

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

4.38 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC found breaches of the regulations and issued action plan requests following the inspection (see Appendix III).

Strategy, clinical governance and partnerships

4.39 Oxleas NHS Foundation Trust was commissioned as the lead provider of health care at Rochester. We saw evidence of collaboration between partners to improve services. However, the lines of accountability between enabling and delivery of health care were not sufficiently clear. Arrangements to deliver health care on the Cookham Wood site had progressed and we had no immediate concerns about the health care proposals within this particular location.

4.40 We criticised clinical governance processes at our last inspection and these concerns remained. Local leadership was reactive, focusing unavoidably on resolving day-to-day problems. Regular audit produced useful data, but the analysis was weaker, limiting improvement. Risk management arrangements did not adequately capture some of the current, complex health care issues being experienced within the prison. We did see examples of learning and changes in practice as a result of incidents, including deaths-in-custody. However, not all lower-level clinical concerns were captured, and the response to complaints could still be cursory and without adequate explanation around clinical decision making.

4.41 Overall, we found health care provision was not always commensurate with need. The complexity of the site, regime pressure, staffing profile and health care operating systems were combining to generate some legitimate concerns among patients about their care. This included frequently cancelled appointments and failures to consistently supply prescribed medication. For example, in our survey, only 14% of prisoners said it was easy to see a GP compared with 25% reported at similar prisons, and only 21% of those surveyed said the quality of provision was very or quite good against 37% for the comparator. Attempts had been made to engage with patients to better understand their concerns, but this was limited to a small number of individuals. There were no ‘health champions’ on wings, and many prisoners we spoke to were uncomplimentary about health care services.

4.42 Health care support was available 7:30am to 9:00pm on weekdays and 8:00am to 6:00pm. Though staffing was at expected levels, protracted

medicines administration arrangements (see 'Medicines optimisation and pharmacy services' section) meant the primary health care nursing team was usually tied up until lunchtime. In addition, clinics were cancelled or delayed due to prison escort failures and 'did-not-attend' rates were high for reasons that were not properly understood by local health care leaders. Combined with long waits to access the GP, this fragmented delivery of nurse-led clinics and the regular cancellations of important appointments resulted in some clinical risk not always being appropriately escalated (see paragraphs 4.50 to 4.53). Gate passes for health care visitors were not always arranged which meant servicing and repairs had to be rescheduled.

4.43 Training and supervision for staff was in line with expected standards and most staff described being well supported by managers. Several prisoners described health care staff as being rude or inconsiderate, but staff we observed were mostly professional and respectful in manner. Medicines administration created pressure points where both prisoners and staff were more likely to interact poorly due to the frustrations of ineffective processes.

4.44 Most primary care clinics were run from the health care centre located in the 'bottom-end' in the newer section of the prison with treatment rooms opening out into the general waiting area and medicine hatch. Space was tight and not all facilities were fit for purpose. The dental suite in the 'top-end' health care centre in the older part of the prison opened directly onto the medicine queue which was often chaotic and noisy (see paragraphs 4.70 and 4.78). Arrangements to respond to medical emergencies included strategically placed equipment, which was routinely checked. This was accessible to a designated, appropriately trained member of the health care team as part of the rostering arrangements.

Promoting health and well-being

4.45 There was a dedicated health promotion lead on site. This ensured information leaflets on living healthier lives were displayed in the health care departments and occasional promotion events were held.

4.46 Sexual health clinics were run on-site by Kent Community Health NHS Foundation Trust, and patients who required specialist community services appropriately attended external appointments. Waiting lists were in line with the community, and condoms were available from the health centre. Blood-borne virus (BBV) and sexual health testing were offered at reception, and patients could also access a BBV nurse who ran clinics each week.

4.47 There were no other health promotion clinics. Patients who required support with weight management were seen by the nurse providing the response to medical emergencies which meant that appointments were often rushed and not consistently followed-up. There were long waits for people who required bowel screening.

Primary care and inpatient services

4.48 Oxleas NHS Foundation Trust was commissioned to deliver a nurse-led service seven days a week, supported by GP sessions on weekdays. Out of hours was provided by the NHS 111 advice line or emergency services. Most nursing time was spent either administering medicines or responding to unscheduled/urgent care which reduced the opportunity to see patients in scheduled appointments. A nurse was also required to work in reception and saw new arrivals as well as patients being released or transferred.

4.49 Nursing staff screened new arrivals in reception and made appropriate referrals to other services. Standard questions were asked about patients' health, and patients received a secondary screening within seven days.

4.50 Triage arrangements were poorly managed; some patients were seen promptly, while other patient appointments were cancelled more than once due to health care or officer availability, and it could take weeks, or in some instances months, before being seen which we judged as being unsafe. Some patients waited to be seen by the GP when they could have been assessed and treated by a nurse.

4.51 There were two long-term condition nurses employed, and although patients with long-term conditions were seen there were no dedicated, condition-specific clinics provided. Patients who required regular treatment, for example, for wound or weight management were not always seen in a timely fashion and care plans were generic and not personalised.

4.52 Waiting times to access a range of visiting practitioners and allied health care professionals, including a physiotherapist, musculoskeletal practitioner and optician, were reasonable. Some patient records were clear and well completed, but others lacked detail. Treatment plans were not always followed, and patients experienced delays in accessing care appropriate to their needs.

4.53 There were a high number of external hospital appointments cancelled. The reasons for this were not well understood. Many appointments were postponed by external services, but these were also curtailed due to problems within the healthcare department and the prison regime. In addition, not all patients who required monitoring were added to the nurse appointments for the day and some records did not capture clinical need appropriately. Non-attendance appointments were not systematically followed-up which further added to delays, including for those patients waiting for an urgent appointment.

Social care

4.54 Despite an up-to-date memorandum of understanding (MOU) between the prison and the local authority, social care remained under-developed with insufficient oversight by prison leaders. The local

authority had, however, commissioned advocacy services and established a clear complaints process which were set out in the MOU.

4.55 There was an agreed pathway for assessment, with five referrals being received by the local authority since January 2024. None of the submissions had qualified for a personal care package, but we noted the referral tracker lacked information on outcomes and progress. Assurance arrangements were further undermined by the lack of any formal meetings to monitor the process. Not all stipulated reasonable adjustments had been implemented. For example, it had taken months for a handle to be installed in a shower area for someone who had already experienced a fall.

4.56 Any support provided to prisoners by their peers was unsupervised and informal; creating risks, and suggestive of potential unmet need. Most prison staff we spoke to did not understand what social care was or what the potential triggers for a referral would look like. We also identified from health records two prisoners with sensory impairment who did not have a referral or consideration of any reasonable adjustments. There was no information on the wings for prisoners or staff to initiate a referral. Most staff assumed they would just need to contact the prison's equalities team.

Mental health

4.57 Mental health services were stable, had clear leadership and consisted of a mix of psychiatry, psychology, specialist practitioners from nursing and social work backgrounds, health care support workers, a counsellor and a small team of therapists.

4.58 Initial screening identified those individuals arriving at Rochester who required ongoing care. A duty worker promptly triaged all new referrals who were subsequently reviewed at a multidisciplinary care team meeting with allocations to practitioner caseloads following where appropriate. A reasonable range of provision was available and there were no significant vacancies within the team. Work was mostly undertaken on a one-to-one basis, though psychotherapeutic group work was available appropriate to the population's needs. Waits for assessment and ongoing interventions were short. Low intensity support, which generally would be provided by peer networks and social prescribing arrangements in the community, was insufficient. Perhaps reflecting this demand, waiting times for the counselling service were significant with up to a 31-week wait dependent on need.

4.59 Records reviewed indicated regular and qualitative contact by practitioners underpinned by clear care plans. Caseload sizes were reasonable. There were around 114 patients being supported at the time of the inspection, including 10 patients with severe and enduring mental illness. Prescribing reviews and physical health checks occurred in line with national standards. There was little suitable therapeutic space on wings and the team relied heavily on prison escort arrangements to facilitate group work and to escort individuals to the health care centre. As prison escort arrangements were unreliable,

did not attend rates were high, and some important groups were cancelled. The team was expected to support segregation reviews which was not always the best use of its time. Support was also provided for ACCT reviews and members of the team visited the segregation unit, though we were told by officers that input was inconsistent.

4.60 There had only been two patients requiring transfer to hospital under the Mental Health Act in the last 12 months, both of whom were transferred within the Department of Health guidelines. Discharge planning arrangements were generally adequate and liaison with community services and other prison health teams ensured continuity of care post-transfer and release.

Support and treatment for prisoners with addictions and those who misuse substances

4.61 There was a published drug strategy which was under review. Change Grow Live (CGL) provided a comprehensive range of structured, recovery-focused psychological interventions. However, a long-standing vacancy for a local manager meant oversight of the service was lacking. Regional support had not filled this deficit and waiting times were not being monitored, although individual practitioners managed their own caseloads and waiting list well.

4.62 All new receptions were screened for their drug and alcohol needs on the day of arrival. All arrivals were transfers and medically stable. Patients with drug and or alcohol needs were referred to and seen swiftly by the CGL staff. They received harm reduction information on illicit substance misuse in prison during their induction.

4.63 In our survey, 22% of the prisoners said that they had a drug problem when they arrived at the prison, and 58% told us it was easy to get drugs in the prison. The random drug testing indicated that many were using illicit substances regularly (see paragraph 3.35). However, from the data provided to us, only a small number of prisoners found under the influence were being referred to the drug service team.

4.64 The substance misuse service comprised a clinical nurse prescriber supported by regular input from a specialist doctor. Prisoners were able to access methadone and buprenorphine for opiate treatment and review of care was done in line with national standards. The administration of opiate substitution was not being undertaken as per the licence instructions; tablets were being crushed instead of using an appropriate alternative medicine. Staff told us this was done to reduce the risk of diversion and to save time. However, from our observations this was not mitigating either factor. Records were written in a separate electronic information system, although computers were being cabled into offices for a single patient record to be maintained in the future.

4.65 A full-time family worker undertook effective work with men and their families to address relationship issues prior to release. Mutual aid groups attended weekly. Naloxone (see Glossary) was being rolled out

for use in the prison and on release. Most patients were engaged 12 weeks prior to release by the CGL service that managed releases, this team who also remained in contact after release which was a positive initiative.

4.66 An incentivised substance free living (ISFL) unit and drug treatment wing were in place. Those held on the drug treatment wing were isolated from the rest of the jail to prevent the infiltration of drugs, but these security controls were ineffective (see paragraph 3.35). Both units had admission criteria which was not being managed appropriately; both units had people located on them who created drug demand and therefore a supply opportunity. This was evident from the increasing numbers of people found on these wings under the influence.

4.67 The ISFL unit had clear incentivised opportunities and some recovery groups which were appreciated by the men, but the criteria for residence on the unit were unclear. Not all voluntary drug tests were undertaken as required.

Medicines optimisation and pharmacy services

4.68 Oxleas NHS Foundation Trust supplied medicines wing-by-wing to prisoners at two locations ('top-end' and bottom-end' treatment rooms), from an on-site pharmacy located in the 'top-end' health care centre. This pharmacy also served other prisons in the Kent region. The out-of-hours cabinet was well stocked, but the stock control was not sufficiently robust with some balance discrepancies noted.

4.69 There were no air conditioning units, and room temperatures had been recorded at 33 degrees Celsius during August which could affect the integrity of stock. Similarly, records between 2 and 8 August showed fridge temperatures of up to 9.8 degrees Celsius which, despite clear instructions, had not been reported to the pharmacy.

4.70 Morning medicines administration started at 8am and frequently ran into lunchtime which had a significant impact on the prison regime (see paragraph 5.4). We spoke to prisoners who, despite not requiring medication, also had to attend as part of a group being escorted to work or education from their respective wings. Patients on buprenorphine, which was only available in slow dispersible form, residing in the 'bottom-end' of the prison had to be escorted to the 'top-end' area to receive this. Arrangements were chaotic, interspersed with periods of frozen movement when nothing was happening. There was no privacy during administration and the noise in the corridor meant that staff and patients had to shout to be heard. There was a screen at the hatch door which meant that staff and patients had to lean down and put their head at around waist height to communicate with each other.

4.71 An example of the difficulties faced by the pharmacy team was captured in the management of seven-day in-possession (IP) medicines. These were received from the pharmacy as individual

monthly supplies in one bag which were then unpacked and stored before being re-bagged up as a seven-day medicines supply each time they were collected. This was grossly inefficient, time consuming and added to the workload. Indeed, many of these preparations could potentially be provided monthly directly from the pharmacy. Perhaps inevitably, we found occasions where there had been delays experienced in accessing important medicines. Many prisoners expressed concern about this issue and, in our survey, 83% of respondents said they had experienced delays in getting their medication compared to 65% in similar establishments.

4.72 As a further example of storage and supply problems, during the inspection, a patient was supplied with six paracetamol tablets from an over-the-counter pack (containing 16 tablets). These were extracted and supplied in a plastic pouch with no information provided about how to take the medicine.

4.73 There were some examples of positive practice. A dispensing robot was used to make labelled 'pill pouches' for people receiving their medicines daily IP or non in-possession (NIP). The pharmacy supplied multi-compartment compliance packs to people who needed this support. It had sourced one with Braille for a patient so that he could manage his own medicines IP.

4.74 Risk assessments were attached on SystmOne and a RAG rating system (see Glossary) was used. The pharmacists checked these during the clinical screening of prescriptions. All patients had a risk assessment undertaken on arrival at the prison and these were routinely reviewed, which was good.

4.75 A supply of medicines or a prescription was prepared pre-release to ensure continuity of treatment and there where medicine management meetings to monitor trends and risks, including the availability of tradable medicines. These processes covered the concerns about temperature monitoring we observed during the inspection but did not address the other significant problems surrounding medicine management arrangements we observed.

Dental services and oral health

4.76 Kent Community Health NHS Foundation Trust was commissioned to deliver five dental sessions a week which included one nurse triage session. Waiting times for appointments were in line with the community, although there had been a recent dip due to a period of staff absence. The dental nurse gave patients advice on how to minimise deterioration in the health of their teeth and gums. The health care team offered pain relief and antibiotics if required for those awaiting an appointment.

4.77 Care records that we reviewed indicated treatment was well documented and patients had been informed of possible options. The justification for and quality of x-rays was documented and supported by

recent audits; action plans were in place to ensure compliance going forward.

4.78 A considerable number of patients did not attend appointments or were unable to because the dental team did not have dedicated officer support to escort them, which wasted the time available to deliver treatment. In addition, the dental suite was adjacent to the medicines administration hatch and patients waiting for an appointment or their medicines were not well managed which was disruptive and could delay treatment further. (See paragraph 4.70.)

4.79 The dental surgery was functional, and all equipment was well maintained and in good working order. Decontamination procedures were followed, and infection control standards were met. The dental team had their own emergency medicine and shared oxygen with health care which was located nearby.

Section 5 Purposeful activity

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

Time out of cell

Expected outcomes: All prisoners have sufficient time out of cell (see Glossary) and are encouraged to engage in recreational and social activities which support their well-being and promote effective rehabilitation.

5.1 During our roll checks we found almost a quarter of the prison locked up and only 32% of the population to be involved in any purposeful activity. This included around 10% of the population under-employed in wing-related work as cleaners or orderlies. The prison's regime plan had a target of 64% of the population allocated to activities, but its own data showed only around half attended, which concurred with our findings. The core day allowed for around 9.25 hours unlocked Monday to Thursday and around seven hours on Fridays, although we calculated that most prisoners spent around six hours a day out of their cell. For most of the population, there was far too little to do while unlocked.

5.2 The weekend regime alternated each week; one week all prisoners would be unlocked both morning and afternoon for around three hours and the next weekend for just one period each day. Prisoners we spoke to told us that the weekend regime was often shorter than publicised, and we calculated that the amount of time unlocked ranged from three to six hours a day for most.

5.3 Association periods that we observed were often chaotic and poorly supervised (see paragraph 4.3). On some wings there was little control by wing staff whom we often found congregating in wing offices, sometimes behind locked doors. At the end of these periods, we observed some staff having difficulty exerting their authority, with a number of prisoners refusing to go to their cells until they had had a shower.

5.4 For those that did leave the wings to go to activities, there was no free movement and all were escorted, often after lengthy waits for medications to be issued (see paragraph 3.32). No activity sessions that we saw started on time, and movement periods we saw started late and overran, significantly reducing time in activity.

5.5 Association equipment on wings was well used and maintained in good condition, but very few enrichment activities were available (see paragraph 5.30). Exercise yards contained fixed fitness equipment, but many exercise periods were too short and were curtailed at 30 minutes.

5.6 The library was a pleasant space and provided a range of books for readers of all abilities as well as a stock of DVDs that could be borrowed. Although each wing was allocated a two-and-a-half-hour session each week, only around 15 men from each wing were able to attend, mainly due to a lack of staff to escort them to and from the library. Most sessions were empty once the initial group of prisoners had made their book/DVD choices and had been returned to their wings. Due to the lack of free movement, prisoners could no longer drop-in to the library, so if they were not in the first cohort from their wing they would have to wait at least a further week to attend.

5.7 Data showed that only around a third of the population used the library and, in our survey, significantly fewer respondents than in similar prisons said they could visit the library once a week or more.

5.8 Except for some displays in the library, there was little promotion of literacy across the prison, but the monthly book club was a popular event. Although the prison-wide reading strategy was not sufficiently well developed some support for prisoners to improve their reading skills was provided by an enthusiastic team of prisoner Shannon Trust mentors (see Glossary) and the library staff (see paragraph 5.31).

5.9 The prison had gym facilities in both parts of the prison, each having facilities for team games and for cardiovascular fitness and weight training. There was also a centrally located grass football pitch and an all-weather pitch adjacent to the newer wings. The all-weather pitch was being used as an exercise yard for F and G wings which meant it was often unavailable for team sports.

5.10 The allocation system for gym sessions was confusing and both staff and prisoners told us it was ineffective. Prisoners had to make an application to attend sessions which was then considered by the allocations panel and up to three sessions were allocated. However, few sessions ran to capacity leaving both prisoners and PE staff frustrated at the lack of use of the facilities.

5.11 Evening and weekend sessions were appropriately allocated to full-time workers who were not permitted to take time off during the working day to attend the gym. Gym staff had introduced some additional activities during the week to boost attendance outside of timetabled activities, but a shortage of PE staff meant that they were often cancelled.

5.12 Despite an excellent teaching area there were no courses available and links to some other key functions such as health and substance misuse services were weak. The Duke of Edinburgh's Award scheme previously run by the gym had ceased.

Gym classroom

Education, skills and work activities

This part of the report is written by Ofsted inspectors using Ofsted's inspection framework, available at https://www.gov.uk/government/publications/education-inspection-framework.

Ofsted inspects the provision of education, skills and work in custodial establishments using the same inspection framework and methodology it applies to further education and skills provision in the wider community. This covers four areas: quality of education, behaviour and attitudes, personal development and leadership and management. The findings are presented in the order of the learner journey in the establishment. Together with the areas of concern, provided in the summary section of this report, this constitutes Ofsted's assessment of what the establishment does well and what it needs to do better.

5.13 Ofsted made the following assessments about the education, skills and work provision:

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Inadequate

Personal development: Requires improvement

Leadership and management: Inadequate

5.14 Leaders had not planned sufficient spaces in education, skills and work for prisoners to take part in meaningful activities. Consequently, only around a third of prisoners were employed and attending activities. Leaders' plans to increase additional spaces by changing full-time roles to part-time had not been implemented.

5.15 Leaders did not have an accurate and up-to-date assessment of the education and training needs of prisoners. They did not conduct a needs analysis sufficiently frequently and took too long to use its results to revise the curriculum. As a result, leaders had not planned a sufficiently challenging curriculum that met the needs of prisoners in this training prison.

5.16 The vocational curriculum focused too heavily on low level courses that did not meet the aims and aspirations of prisoners to progress on to a tradecraft. For example, prisoners who completed level 1 carpentry were not able to take these skills further. There were no opportunities for prisoners to consolidate or practise their newly acquired skills further through planned work. Prisoners working in serveries were not able to complete accredited courses in food hygiene or food safety that would help them with their longer-term progression.

5.17 Leaders had not planned or implemented an English and mathematics curriculum that met the needs of the men in the prison. Over half of prisoners were assessed as working at pre-entry or entry level in English and mathematics. However, there were almost no stand-alone English and mathematics classes and too few spaces on the preparation for life pathway, which included support for those with the lowest levels of literacy and numeracy. Consequently, prisoners failed to develop their confidence in, and understanding of, mathematics and English to help them in the next stage of their learning or work.

5.18 The allocation process was ineffective. Managers had not ensured that prisoners' starting points were carefully considered to prioritise prisoners' needs. Prisoners' personal aspirations and interests were not considered sufficiently to inform their allocation to education, skills and work. As a result, prisoners often were not interested in the activities that they had been allocated to and did not attend these.

5.19 Leaders and managers had not created a culture that inspired prisoners to improve themselves or their life chances. Prisoners did not routinely demonstrate positive attitudes towards their learning or their experience in the wider prison environment. For example, most prisoners on the digital pathway did not value their course. They felt frustrated by being allocated to courses that did not align with their personal learning plans and identified development targets.

5.20 The small proportion of prisoners who accessed education and skills benefitted from logically planned lessons. As a result, a few prisoners were able to build their knowledge and skills incrementally. For example, prisoners on the stonemason's course learnt about the properties of different types of stone. They then moved on to preparing stone using a four-stage process before applying this understanding to preparing sophisticated structures and carvings.

5.21 Leaders had not introduced industry accreditations for prisoners undertaking vocational training. Trainers in stonemasonry followed an accredited course and prisoners produced work that met the requirements. However, they were not able to gain accreditation which would support them in their future careers.

5.22 The vast majority of prisoners did not benefit from access to high quality education, skills and work. The small number of prisoners who attended benefited from tutors and trainers who used a range of strategies to teach effectively. For example, in digital branding, mathematics tutors used matching tasks, worked examples and practice tasks to teach prisoners about metric conversions. Vocational tutors used their industry experience in clear demonstrations and explanations which showed prisoners how to lay bricks, carve stone and cut window frames to size.

5.23 Tutors and trainers tailored teaching appropriately to provide support for prisoners with additional learning support needs. For example, they worked closely with prisoners with neurodiverse needs. They would break instructions down into manageable chunks enabling prisoners to understand what they were being taught and retain their newly acquired knowledge.

5.24 The Prison Education Framework (PEF) provider, Milton Keynes College, provided education and vocational training in the prison. Managers had not ensured that courses met the needs of the population. Planned pathways such as digital skills included English and mathematics content but lacked training to support prisoners to develop their digital skills. Long term vacancies for English and mathematics tutors restricted prisoners' access to courses in mathematics and English. Tutors had designed their curriculums in a logical order that met prisoners' needs. The small number of prisoners who attended, learned basic knowledge and skills before moving on to more complex topics. For example, in industrial cleaning, prisoners developed a very sound understanding of the use of personal protective equipment (PPE) and the safe use of chemicals before embarking on practical activities. Teachers were experienced and appropriately qualified for their roles. They assessed learning and gave constructive feedback which helped prisoners to improve their work. However, they did not always correct prisoners' inappropriate annotations on their workbooks. Very few prisoners gained their target qualifications. For those who did complete, many did not achieve within the planned timescale.

5.25 Leaders had not increased prisoners access to the Virtual Campus since the previous inspection. Prisoners in work and industries did not have access to this resource. Approximately 12 prisoners received effective support from education staff while following Open University or distance learning courses at level 3 or higher. These prisoners had access to the Virtual Campus and were allowed laptop computers in their cells.

5.26 Too many prisoners did not complete progress to workbooks as they did not see their relevance. Wing workers and those working in the windows workshop did not complete progress to workbooks. As a result, they had no way to recognise or capture learning, reflect on the transferrable skills they were developing or demonstrate these when seeking future employment.

5.27 The vast majority of prisoners did not benefit from their learning or work. The small minority of prisoners working in the transformation team and stonemasonry took pride in their work. They appreciated the contribution they made to the appearance of the prison estate and enjoyed displaying their work publicly. They were aware of how this positively affected their own morale and that of others. Peer supporters were proud of the work they did in workshops, classrooms and the library.

5.28 Prisoners felt safe while in education and in industries. Prisoners at work and in vocational training understood the purpose and need for PPE, and most used it appropriately.

5.29 Leaders and managers rightly recognised the negative impact of the unpredictable regime on prisoners' attendance at education, skills and work. Punctuality was extremely poor for those prisoners who did attend their allocated activities. As a result, most prisoners missed significant amounts of learning or work and did not make appropriate progress. Too few prisoners progressed to further learning.

5.30 Leaders had not provided a sufficient range of activities for prisoners to explore and develop wider interests outside education, skills and work activities. Very few prisoners were able to improve their confidence and resilience through activities such as a drama group and guitar lessons. The availability of these activities was poor.

5.31 Leaders had been too slow to implement a strategy to improve reading across the prison. Leaders acknowledged that the roll-out of the reading strategy was recent and that the impact was negligible. The PEF provider had implemented a strategy, but this was limited to prisoners who attended education. A book corner in education encouraged prisoners to read more and review the books that they had read. However, activities were too narrow in their impact on most of the population. Prisoners had limited opportunities to visit the library to select reading materials or access computers. A small proportion of prisoners benefited from the support that they received to improve their reading skills by Shannon Trust mentors.

5.32 Prison, education, and careers information, advice and guidance (CIAG) staff worked together well to identify appropriate education and employment pathways for new arrivals based on their starting points and sentence restrictions. However, too many prisoners who had been at the prison prior to the new staff being appointed did not have an effective initial CIAG meeting to discuss their career plans and goals. As a result, they did not have clear learning plans aligned to their interests and ambitions.

5.33 Staff did not routinely promote the fundamental values of tolerance and respect. Prisoners in education and prison industries had only a very superficial awareness about how they could recognise the risks they could face from people who had extreme views or the steps they could take to protect themselves from these. Prisoners had limited recall of any input or teaching by staff to help develop their understanding of these topics.

5.34 Leaders and managers did not have sufficient oversight of the impact of actions arising from activities such as the quality improvement group meetings. Not all staff updated the action plans. Consequently, leaders did not have an up-to-date understanding of progress against targets for improvement and were not able to put in place appropriate challenge or remedial actions. Consequently, they had not successfully addressed the significant weaknesses highlighted at the previous inspection.

5.35 Leaders and managers did not follow their own policy for prisoners' pay. For example, the policy was clear that prisoners should be working towards level 1 in English and/or mathematics to progress to the next level in education or work. In addition, the local pay policy did not incentivise prisoners to attend education.

Section 6 Preparation for release

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

Children and families and contact with the outside world

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

6.1 There was reasonable support available to help prisoners to build and maintain family ties. The family support provider, the Prison Advice and Care Trust (PACT), staffed the visits hall and visitors' centre, and employed a family engagement worker who provided casework with individual prisoners and liaised with families.

6.2 The visitors' centre was somewhat tired but provided an acceptable space for PACT workers to greet visitors and offer them a hot drink. The visits hall was welcoming, with a well-equipped play area for younger children and a tea bar serving a good range of hot and cold food.

Visitors' centre

Visits hall (left) and children's play area

6.3 Social visits were held every day of the week and twice on Saturdays. Despite this, there were not enough slots available for all prisoners to take advantage of their monthly visits allowance. Sessions lasted for almost two hours, which was an improvement from our last inspection, although only 27% of prisoners in our survey said that they usually started on time, and we were told that they often commenced late.

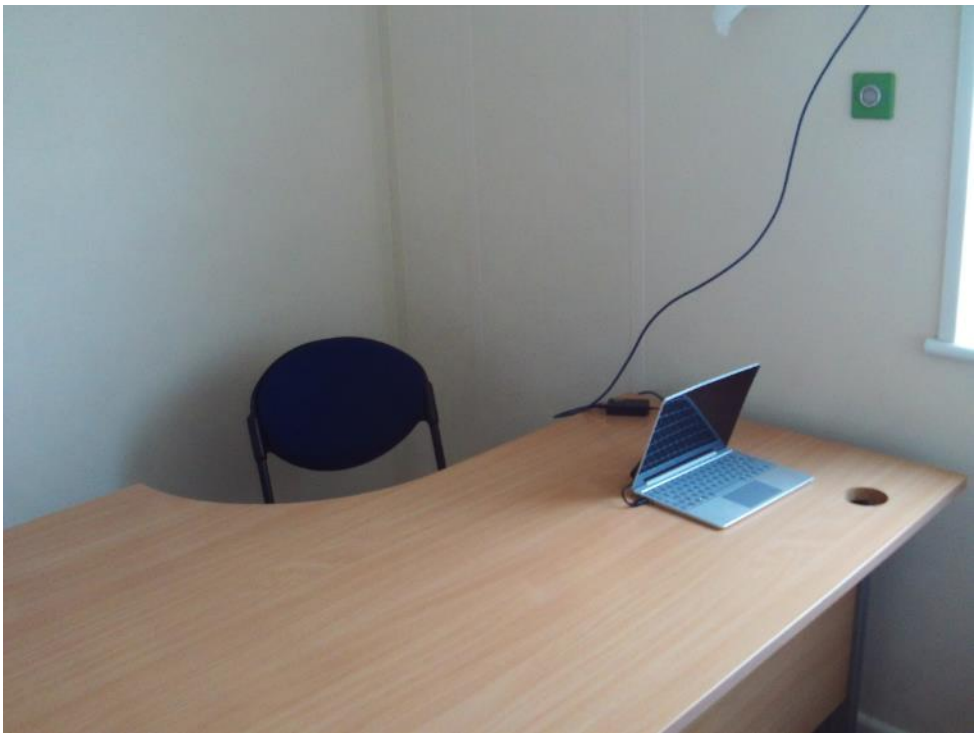
6.4 In our survey, just 55% of prisoners said that their visitors were usually treated with respect, which was lower than comparable prisons. We found evidence of some disrespectful treatment of visitors, particularly during entry searches by prison staff. Staff and prisoners described incidents of visitors being left upset following excessive searches aided

by detection dogs, and prisoners frequently spoke about staff treating their visitors disrespectfully.

6.5 Family days were held monthly. Although they were short at around three hours, prisoners spoke positively of them. The prison had also held two 'enrichment events' in the last year for prisoners with neurodiverse needs and those serving life sentences to spend additional time with their families. (See paragraph 4.32.)

6.6 Prison leaders maintained a record of prisoners who did not receive visitors. Official Prison Visitors organised through the chaplaincy were available for some of them, although there was no other provision for these individuals.

6.7 Terminals were available for social video calls each day, but these were under-utilised with more than half of available slots unused in the six months prior to our visit. Staff and prisoners reported that the service was unreliable, which contributed to its unpopularity.



Video visit room

6.8 In-cell telephones to keep in touch with their families and friends, were not always working (see paragraph 4.6). The Email a Prisoner scheme was well used.

Reducing reoffending

Expected outcomes: Prisoners are helped to change behaviours that contribute to offending. Staff help prisoners to demonstrate their progress.

6.9 HMP Rochester held a diverse population of prisoners, incorporating varying sentence lengths, indeterminate sentences, prisoners nearing release and an increased proportion of recalls to custody. Over half (56%) of the prisoner population was assessed as posing a high or very high risk of serious harm. The need for effective offender management was high.

6.10 The prison had an up-to-date reducing reoffending strategy and regularly reviewed the makeup of the population at monthly reducing reoffending meetings. These meetings were happening regularly, but attendance was sporadic, and actions were not driving improvement. There had, however, been some progress in preparing prisoners for employment on release.

6.11 The offender management unit (OMU) team was committed and mutually supportive but was critically short of trained probation staff to manage high-risk prisoners. Between mid-January and July 2024, the five full-time probation-trained prisoner offender manager (POM) posts had been vacant, and only one newly qualified probation officer was in post at the time of our inspection. A variety of factors meant the 1.5 senior probation officer (SPO) posts had also not always been filled for a substantial period. Although the 10 prison POMs were in post, not all were available for work. Caseloads for case administrators and POMs were high. This had been compounded by an increase in the population in early 2024 when new accommodation opened at the prison and the additional work required to deliver SDS 40 (see Glossary). The full-time SPO held a caseload of 120 prisoners which was not viable even without the supervision, quality assurance and leadership input required as part of their role. Negative outcomes due to the staffing difficulties included lack of robust risk management, weaknesses in public protection and inadequate contact with prisoners.

6.12 Interim solutions to the gaps in staffing included two probation officers who worked remotely, two community-based probation officers who each worked as POMs two days weekly for small caseloads of high-risk prisoners, and a probation service officer who supported high-risk prisoner case management. These were useful initiatives by leaders but were not a long-term solution to the prison's needs.

6.13 OMU managers were described by their staff as being supportive and always available to give help. To relieve some of the pressure on their team, managers were taking on work which should have been completed by others. This gave them less time to focus on areas such as quality assurance and staff supervision.

6.14 Processes such as categorisation reviews or parole board preparation took a lot of POM time, and they described limited time to develop meaningful relationships with prisoners. Prisoners consistently reported a lack of POM contact, despite their various attempts to reach them through repeated applications or by asking other staff members to email them. Some records revealed no recorded contact within the past 24 months which was very poor. The infrequent contact between prisoners and POMs was not helped by key work that was too limited and had no impact in supporting sentence progression (see paragraph 4.4). A small number of cases we looked at had better levels of key work involvement which included liaison with the POM.

6.15 In our survey, only 42% of respondents who had a custody plan said that someone was helping them to achieve their targets. Prisoners struggled to demonstrate progression in their sentence because of the lack of risk reduction work and purposeful activity available to them. Many did not feel the prison provided an environment conducive to personal development or sentence progression. Prisoners with indeterminate sentences or who were approaching parole expressed greater negativity as they understood a failure to demonstrate progress could affect their chances of a progressive move. They were frustrated by the limited opportunities to complete alternative non-accredited interventions that could help them evidence their risk reduction efforts.

6.16 During the inspection, we observed numerous challenges related to prisoner appointments and meeting spaces which hampered offender management. Escorting prisoners to scheduled appointments often resulted in late arrivals or missed appointments. Rooms on the residential wings were unsuitable for conducting private and confidential conversations, such as offence-focused work.

6.17 The proportion of prisoners who did not have an offender assessment system report and sentence plan (OASys) had increased to around 13% of prisoners. One third had not had a review for more than 12 months which was also higher than at the previous inspection. In the sample reviewed, OASys completed by community offender managers (COMs) were generally of a good standard. Those completed by POMs at Rochester identified areas of need but did not elaborate sufficiently on the impact of potential risks or how to manage these. Sentence plans in these cases were not always thoroughly informed by the risk management plan. A lack of identification and mitigation of the serious risks associated with domestic abuse, in particular, was a common theme in prison completed assessments for OASys, Multi-Agency Public Protection Arrangements (MAPPA) and release on temporary licence (ROTL) assessments.

6.18 Neurodivergent prisoners were identified consistently but OASys assessments often lacked detail on the support needed, despite helpful guides being included on relevant prisoners' electronic case notes. (See paragraph 4.32.)

6.19 There was some dedicated resource within the POM group to provide support to young adults transitioning from the youth custody estate.

There was though little evidence of maturity screening being used to identify those who might benefit from completion of the HM Prison and Probation Service (HMPPS) resource pack designed to foster engagement and support the development of maturity in young adults.

6.20 Handover meetings where responsibility for case management moved from the POM to the COM were happening with the prisoner present but there was a lack of continued liaison between the prison and the community. We found instances where emails from COMs regarding further meetings, information gathering, or release planning were left unanswered. In one case a prisoner did not have an allocated COM, resulting in no handover taking place and remedial action was only initiated when the prison-based pre-release team (see paragraph 6.35) became involved.

6.21 Categorisation reviews did not routinely include prisoners' input, the quality of assessment was variable and there were delays in some of them being finalised. Due to the population pressures on the prison estate, prisoners could experience long waits to transfer to other category C prisons to aid their progression. However, the timeliness of moves to open prisons for those assessed as suitable had improved since the last inspection. There had also been delays in the release of some prisoners who were suitable for home detention curfew often for reasons outside the direct control of the prison.

6.22 ROTL had been used for only a small number of prisoners in the previous year to build family ties prior to release. Prisoners were rarely involved in their ROTL boards and only half of the six sets of ROTL paperwork reviewed evidenced defensible decisions to grant ROTL having been made.

6.23 Data from the prison showed 61 prisoners with indeterminate sentences, including 28 who had been recalled to custody and 16 with indeterminate sentences for public protection. Support for these prisoners was under-developed with, for example, just one lifer forum taking place in 2024 and one extended family visit session. Prisoners we spoke to did not see the forum as a way to influence meaningful change. They expressed concerns about the lack of opportunities to make progress within their sentences and develop essential life skills in preparation for their eventual release.

6.24 Video links for parole and meetings with external probation staff were frequently held in inappropriate spaces, with OMU staff sometimes giving up their office so important prisoner appointments could go ahead. Ninety-nine parole boards had been held in the previous 12 months which was an increase since the last inspection and had resulted in 42 directed releases and six moves to open prisons.

Public protection

Expected outcomes: Prisoners' risk of serious harm to others is managed effectively. Prisoners are helped to reduce high risk of harm behaviours.

6.25 There had not been an interdepartmental risk management meeting (IRMM) or similar so far in 2024 which was a gap in the oversight given to the management of prisoners who posed the most risk. The recent reintroduction of a public protection steering group evidenced leaders' intention to improve in this area and an IRMM was scheduled for soon after our inspection which again was a positive step.

6.26 The need for such meetings was evidenced in our case sample where we found two prisoners with unaddressed public protection concerns among the 15 that we looked at in detail. These were raised with OMU leaders for further investigation and action.

6.27 Completed risk management plans reviewed were generally of a good standard with some that were excellent. However, we also found some prisoners in our sample for whom these necessary plans had not been completed by their COM which was a gap.

6.28 MAPPA information sharing forms identified relevant needs, but most assessors did not identify when risks were likely to increase or recommend actions to address and manage those risks. Most did not draw conclusions based on the available information and knowledge of the prisoner. OMU attendance at community boards to discuss higher level MAPPA management prisoners was happening with support from regional senior managers.

6.29 At the time of our inspection, there were no prisoners subject to offence-related communications monitoring which was unusual for the population held. Our case sample evidenced that monitoring of telephone calls and mail was not always being used when it should have been. Newly received prisoners were being screened to put any required contact restrictions in place, but there were no prisoners subject to offence-related communications monitoring during the inspection. This was unusual for the population held, and our case sample evidenced that monitoring of telephone calls and mail was not always being used when it should have been.

Interventions and support

Expected outcomes: Prisoners are able to access support and interventions designed to reduce reoffending and promote effective resettlement.

6.30 Two accredited interventions suitable for the population's needs were offered, however one of these, Building Better Relationships, (for use with prisoners with intimate partner violence offences) was facilitated by staff from another prison and only ran sporadically. Weaknesses in

the identification of domestic abuse meant there may have been unidentified need for this intervention (see paragraph 6.17). The Thinking Skills Programme (TSP), designed to help prisoners develop cognitive skills to manage their risks, ran more regularly with the prison's own facilitators. A family member was able to attend a prisoner's post programme review to help reinforce positive changes in behaviour going forward, which was useful.

6.31 Moves to other prisons to complete accredited programmes not available at Rochester were often difficult and time-consuming to arrange. Some prisoners were disappointed at being transferred to Rochester when programmes on their sentence plan could not be completed there.

6.32 The Sycamore Tree course (a community volunteer-led victim awareness programme) organised by the chaplaincy team had good prisoner take up, running several times a year (see paragraph 4.36).

6.33 Work to help prisoners improve their employment prospects when released was developing well with a few prisoners having secured job offers while at the prison. A prison employment lead (PEL) who was part of the New Futures Network (NFN) (an HMPPS initiative which brokers partnerships between prisons and employers) took the lead in this work, organising training courses and employer events for prisoners. A 'building business' course for prisoners interested in starting their own businesses when released was taking place during our inspection.

6.34 Also, as part of the NFN support, a lead member of staff in the prison helped prisoners obtain identification, open bank accounts with HSBC or reactivate existing bank accounts. Help to apply for a driving licence was also offered. Further finance, benefits, and debt advice was offered by the Department for Work and Pensions (DWP). Prisoners were given support with benefit entitlements and claims. They could also attend a DWP run 'departure lounge' in the visitors' centre when released to progress their claims prior to meeting a work coach at their allocated DWP office in the community. In collaboration with the PEL, DWP had funded a traffic management course for prisoners and the 12 participants had gained an industry-recognised qualification.

Returning to the community

Expected outcomes: Prisoners' specific reintegration needs are met through good multi-agency working to maximise the likelihood of successful resettlement on release.

6.35 Prison data showed that 592 prisoners had been released in the previous 12 months. The pre-release team offered good support to prisoners within 12 weeks of release, including those who were high risk, which we do not always see at other prisons. We received positive feedback from prisoners about their work. The pre-release

assessments reviewed during the inspection were of excellent quality with an impressive level of detail and information rarely observed elsewhere. The assessors demonstrated a clear understanding of resettlement related risk concerns, and we found evidence of ongoing liaison with COMs and prompt referrals to other release agencies.

6.36 The co-location of agencies involved in pre-release work in the prison supported communication and information sharing. These included the information advice and guidance provider (CXK, a charity that provides support to help people find work or move into learning or training) who supported prisoners with CVs and disclosure letters, a housing support worker from Interventions Alliance, the PEL and banking and identification worker, DWP staff, and the pre-release team. There was good use of peer support in these areas.

6.37 A multi-agency release board had recently been introduced which was a promising initiative. The first meeting had been dedicated to prisoners due to be released as part of the SDS40 initiative to strengthen oversight of plans for this group.

6.38 There were gaps in the data provided by the prison about accommodation outcomes. Information about accommodation on the day of release was not available for 17% of prisoners released over the previous 12 months. Only 49% of those recorded had sustainable accommodation to go to and 9% had been released homeless.

6.39 Release day arrangements were reasonable. Searching in reception was proportionate and prisoners could get plain bags for their belongings. There was some donated clothing for prisoners with nothing suitable to wear and they were provided with a rail travel warrant.

Section 7 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy prison.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2021, we found that outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

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

There should be clear measures to recruit, train, and retain operational staff to keep prisoners safe and healthy and deliver a full rehabilitative regime.
Partially achieved

The strategy to improve safety outcomes should be informed by good data analysis and include an effective action plan to reduce violence and self-harm.
Not achieved

Recommendations

Rewards and sanctions should motivate prisoners to participate in the regime and support their progression.
Not achieved

Action to address issues identified at the segregation monitoring and review group should be specific, measurable and time bound to make sure that the process deals with the most serious offences effectively.
Not achieved

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

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

Health care staff should attend all segregation reviews.
Partially achieved

Target setting in segregation paperwork and reintegration plans should be meaningful and tailored to the individual.
Not achieved

Prisoners should only be segregated pending adjudication if they pose a significant risk.
Not achieved

Security meetings should lead to clear action plans that are specific, measurable and time bound to reduce the security risks facing the prison.
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2021, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

Staffing levels and prisoners' time out of cell should be increased to facilitate the development of productive and positive relationships.
Partially achieved

Cells in the older part of the prison should be taken out of commission and refurbished or replaced to ensure that all prisoners live in cells that are safe, decent and comfortable.
Not achieved

Prisoners should have ready access to their stored property. Requests for access should be dealt with within agreed and published time scales following consultation with prisoners.
Achieved

Robust governance procedures, including consistent incident reporting and investigation, should be implemented to ensure that concerns affecting patient safety are promptly addressed.
Not achieved

Recommendations

Robust tracking and management intervention should be introduced to ensure the timeliness of responses to applications.
Not achieved

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

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

Patients should have timely access to secondary care treatment and duty of candour should be applied when a patient's appointment is cancelled.
Not achieved

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

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

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

Purposeful activity

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

At the last inspection, in 2021, we found that outcomes for prisoners were poor against this healthy prison test.

Key recommendations

All prisoners should have adequate time out of cell to participate in a regime that includes purposeful activity, time to complete domestic chores and the opportunity to socialise with their peers.
Not achieved

Recommendations

Leaders and managers must urgently prioritise increasing the number of face-to-face places in education, skills and work activities so that a significantly larger number of prisoners are able to access and attend activities.
Not achieved

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

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

Rehabilitation and release planning / Preparation for release

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

At the last inspection, in 2021, we found that outcomes for prisoners were reasonably good against this healthy prison test.

Recommendations

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

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

Public protection monitoring should be timely and effective to reduce the risks of harassment and further criminal activity.
Not achieved

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

Appendix I About our inspections and reports

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

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

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

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

Respect
Prisoners are treated with respect for their human dignity.

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

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

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

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

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

concerns. Procedures to safeguard outcomes are in place.

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

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

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for prisoners. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

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

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

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

This report

This report outlines the priority and key concerns from the inspection and our judgements against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 6, 2023) (available on our website at Expectations – HM Inspectorate

of Prisons (justiceinspectorates.gov.uk). Section 7 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

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

Inspection team

This inspection was carried out by:

Martin Lomas	Deputy Chief Inspector
Sara Pennington	Team leader
Natalie Heeks	Inspector
Lindsay Jones	Inspector
Paul Rowlands	Inspector
Rick Wright	Inspector
Harriet Leaver	Inspector
Angela Johnson	Inspector
Tareek Deacon	Researcher
Emma King	Researcher
Helen Ranns	Researcher
Helen Downham	Researcher
Jasjeet Sohal	Research
Steve Eley	Lead health and social care inspector
Tania Osborne	Health and social care inspector
Jennifer Oliphant	GPhC Inspector
Bev Grey	Care Quality Commission inspector
Carolyn Brownsea	Ofsted inspector
Andrea McMahan	Ofsted inspector
Vicki Faulkner	Ofsted inspector
Diane Koppit	Ofsted inspector
Dionne Walker	Offender management inspector
Joanna Luck	Offender management 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

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

Family days
Many prisons, in addition to normal visits, arrange ‘family days’ throughout the year. These are usually open to all prisoners who have small children, grandchildren, or other young relatives.

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.

MAPPA
Multi-Agency Public Protection Arrangements: the set of arrangements through which the police, probation and prison services work together with other agencies to manage the risks posed by violent, sexual and terrorism offenders living in the community, to protect the public.

Naloxone
A drug that rapidly reverses the effects of an opioid overdose, and therefore can help to prevent overdose deaths.

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.

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

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

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

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

RAG
A RAG (red, amber, green) risk assessment is a way of viewing the status of a project or situation. Red – serious concerns or high risks; amber – potential concerns or moderate risks; green – no concerns, good practice.

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

Shannon Trust
A national charity which provides peer-mentored reading plan resources and training to prisons.

Special purpose licence ROTL
Special purpose licence allows prisoners to respond to exceptional, personal circumstances, for example, for medical treatment and other criminal justice needs. Release is usually for a few hours.

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

Appendix III Care Quality Commission Requirement Notice

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

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

Regulation 12 Safe Care and Treatment

12. -

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;

c. ensuring that persons providing care or treatment to service users have the qualifications, competence, skills and experience to do so safely;

d. ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way;

e. ensuring that the equipment used by the service provider for providing care or treatment to a service user is safe for such use and is used in a safe way;

f. where equipment or medicines are supplied by the service provider, ensuring that there are sufficient quantities of these to ensure the safety of service users and to meet their needs;

g. the proper and safe management of medicines;

h. assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated;

i. where responsibility for the care and treatment of service users is shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons to ensure that timely care planning takes place to ensure the health, safety and welfare of the service users.

How the regulation was not being met

You failed to provide safe care and treatment to all patients.

- Patients who missed internal and external secondary care appointments were not consistently followed-up to ensure a subsequent appointment was booked, this included patients who were referred under the two week wait pathway.
- GP and nurse triage lists were not managed effectively which meant that there were long delays in patient waits and some patient care was unsafe.
- There was an insufficient number of nurse clinics to see and treat patients. Few nurse-led clinics were run each month and most patients were seen and treated by the nurse holding the emergency alarm.
- Patient care records lacked detail, care plans were not personalised and did not consistently provide clarity for staff on how patients should be cared for.
- Some patient care was unsafe, concerns identified were not consistently escalated or followed up. For example, we found some patients did not have their wounds or weight loss managed and monitored appropriately and GP recommendations and referrals to specialists were not always made.
- Patient medicines were not well managed, there was poor stock control and medicines could not always be located when patients came to collect their medicines.
- Staff failed to consistently administer medicines to patients in line with the patients' prescriptions or follow-up patients who had not collected their critical and important medicines to ensure the use of medicines was optimised.
- Medicines were not always stored at the correct fridge or room temperature and appropriate action was not taken when this was observed and recorded by staff.

This was in breach of regulation 12(1)(2)(a)(g)(i) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulation 16: Receiving and acting on complaints -

1. Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.

2. The registered person must establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity.

3. The registered person must provide to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request, a summary of—

a. complaints made under such complaints system,

b. responses made by the registered person to such complaints and any further correspondence with the complainants in relation to such complaints, and

c. any other relevant information in relation to such complaints as the Commission may request.

How the regulation was not being met:

Patients' complaints were not always received in a timely manner, and the cause of the sometimes very long delays had not been investigated.

- Staff had not consistently investigated complaints or used appropriate language to be considerate of patients' feelings in the responses.
- The monitoring and outcomes of complaints were not routinely documented.

This was in breach of regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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;

c. maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

d. maintain securely such other records as are necessary to be kept in relation to—

i. persons employed in the carrying on of the regulated activity, and

ii. the management of the regulated activity;

e. seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services;

f. evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

3. The registered person must send to the Commission, when requested to do so and by no later than 28 days beginning on the day after receipt of the request—

a. a written report setting out how, and the extent to which, in the opinion of the registered person, the requirements of paragraph (2)(a) and (b) are being complied with, and

b. any plans that the registered person has for improving the standard of the services provided to service users with a view to ensuring their health and welfare.

How the regulation was not being met:

The risk register was not managed effectively. Staff had not identified all risks to patient safety and mitigating actions recorded on the register were not clearly defined or monitored on a regular basis, with suitable action taken.

- Staff had not consistently reported incidents or categorised them in accordance with the provider's policy.
- There was no oversight or auditing of the patient triage process or management of internal and external secondary care appointments. Patients frequently had long delays in accessing healthcare and the waiting list was not reflective of the time patients waited to see a medical professional.
- Audits had failed to identify that patient care plans and records were not always personalised and lacked detail.

This was in breach of regulation 17(1)(2)(a(b)(c)(dii)(e)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulation 18 – Staffing -

1. Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part.

2. Persons employed by the service provider in the provision of a regulated activity must—

a. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform

b. be enabled where appropriate to obtain further qualifications appropriate to the work they perform, and

c. where such persons are health care professionals, social workers or other professionals registered with a health care or social care regulator,

be enabled to provide evidence to the regulator in question demonstrating, where it is possible to do so, that they continue to meet the professional standards which are a condition of their ability to practise or a requirement of their role.

How the regulation was not being met:

- Staff were not deployed effectively, and it was difficult to ascertain whether there were adequate staff numbers to provide safe care to patients. When staffing levels were lower than the agreed number, this was not escalated and acted on. The head of healthcare and primary care lead regularly worked clinically to support staff.

This was in breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Appendix IV Further resources

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

Prison population profile

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

Prisoner survey methodology and results

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

Prison staff survey

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

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

This publication is available for download at: Our reports – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)

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