

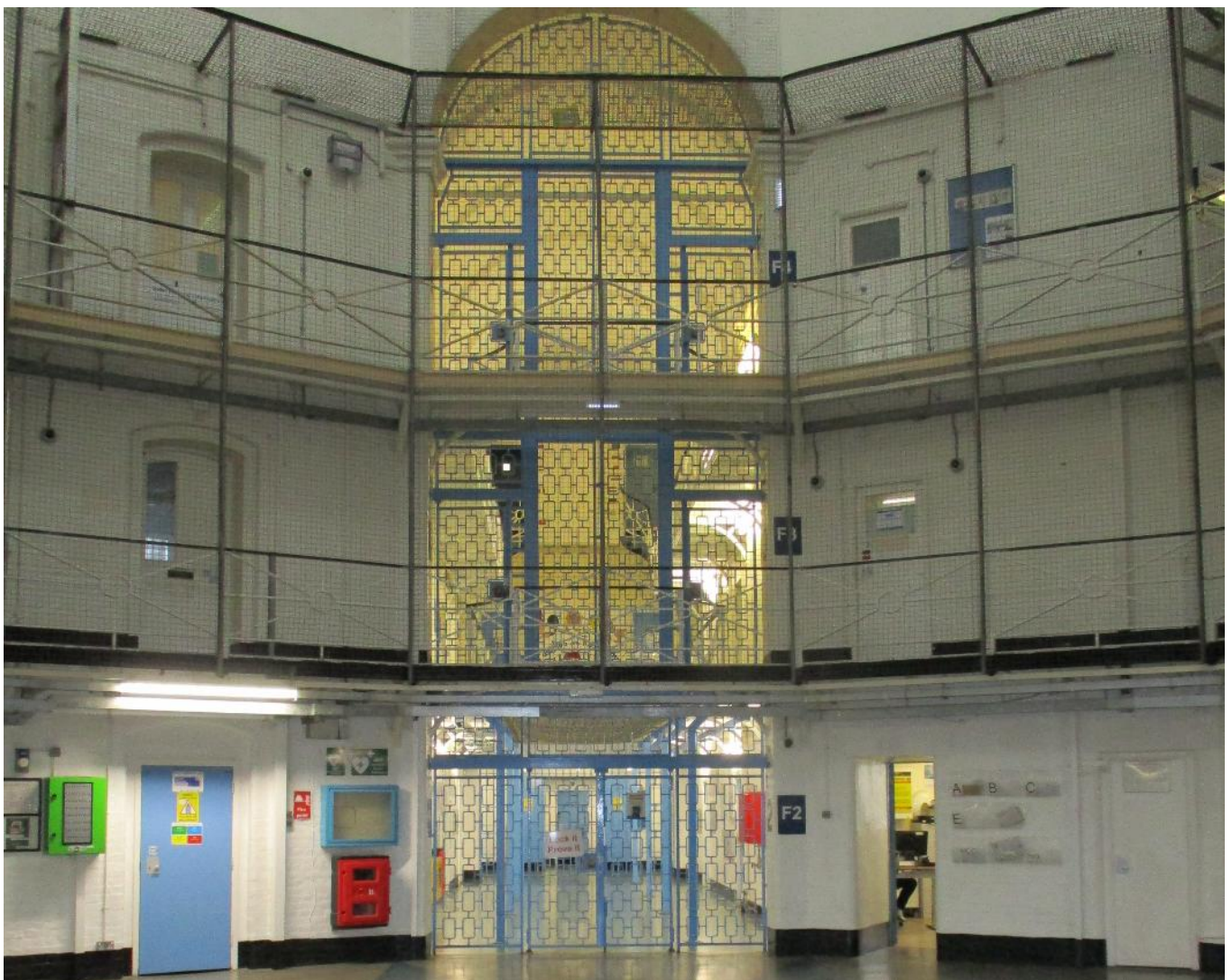


Report on an independent review of progress at

## **HMP Wandsworth**

by HM Chief Inspector of Prisons

31 March – 2 April 2025



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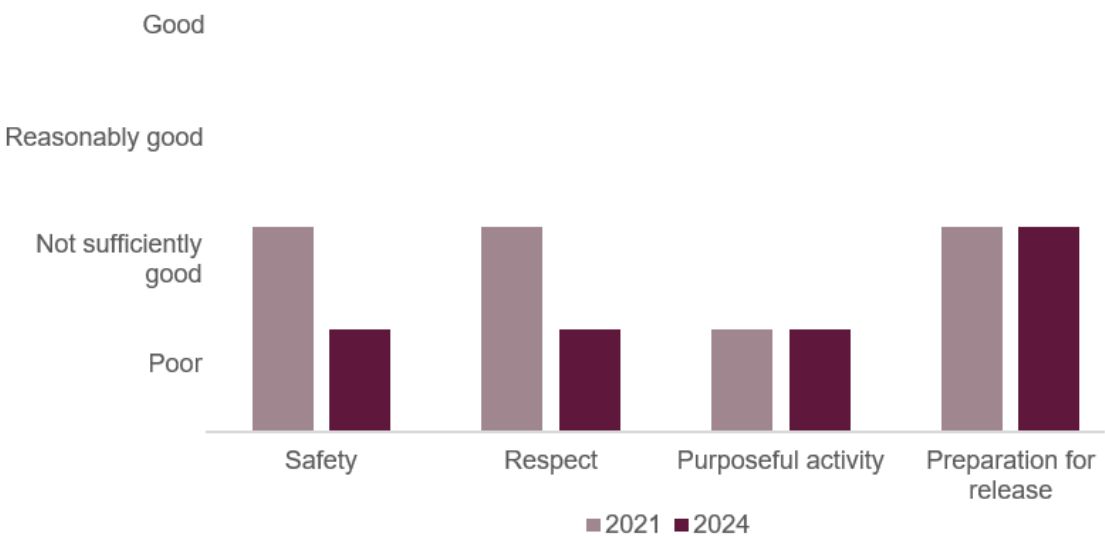
# Section 1 Chief Inspector’s summary

- 1.1 HMP Wandsworth is a local category B reception and resettlement prison for men. It has a high turnover of prisoners and about half of men are on remand.
- 1.2 This review visit followed up on the concerns we raised at our last inspection of HMP Wandsworth in 2024.

## What we found at our last inspection

- 1.3 At our previous inspections of HMP Wandsworth in 2021 and 2024 we made the following judgements about outcomes for prisoners.

**Figure 1: HMP Wandsworth healthy prison outcomes in 2021 and 2024**  
Note: rehabilitation and release planning became ‘preparation for release’ in October 2023.



- 1.4 At the full inspection in 2024, outcomes were largely poor and still declining across a range of areas. The wings were chaotic and the use of illicit drugs was widespread, while supply reduction work lacked rigour. Random mandatory drug testing (MDT) had only just restarted and showed that around 44% of prisoners were using drugs. Despite a high-profile escape, there were ongoing weaknesses in procedural and dynamic security.
- 1.5 The rate of self-harm was high and rising, and there had been 10 self-inflicted deaths since the previous inspection. Violence, including serious incidents, had also increased. This was higher than at most similar prisons.
- 1.6 The prison was badly overcrowded and living conditions were poor. In our survey, only 41% of prisoners said that most staff treated them with respect. This was much worse than at other prisons, and it was clear

that many staff were unable or unwilling to engage positively with prisoners.

- 1.7 Time out of cell was very limited, partly due to high rates of staff absence, and the regime was extremely unpredictable. There was a lack of work and education, and attendance was low. Pre-release support was weak, especially for the high number of remand prisoners.
- 1.8 Poor leadership at every level had allowed these systemic and cultural failures to develop.

## **What we found during this review visit**

- 1.9 A new governor had brought energy and focus to the prison and was prioritising critical areas of safety and decency. He was assisted by a supportive prison group director and there was a more cohesive senior team. Both staff and prisoners told us there was a renewed sense of purpose in the prison.
- 1.10 The safer custody and security teams had been strengthened, and the rates of violence and self-harm had both reduced. There was a more focused approach to reducing the supply of drugs and, while still too high, the MDT positive rate was lower than at the inspection.
- 1.11 There had been substantial investment in staffing and training. Many experienced staff had been transferred from other prisons on a temporary basis. This had helped to bring a greater level of stability. However, the overall level of experience and capability remained low, and middle managers lacked visibility. Applications and complaints processes were improving too slowly and many prisoners were still very frustrated about the difficulty of getting basic matters dealt with.
- 1.12 The prison's capacity had been reduced by 150 spaces and this had helped to provide a calmer atmosphere. Capacity was due to be reduced by a further 150 spaces in the near future. Although the prison environment had improved, some much-needed big projects, such as the shower refurbishments, had yet to be completed.
- 1.13 The decision to turn the Trinity unit wings into a more purposeful working unit for prisoners on the enhanced level of the incentives scheme had been successful. Leaders had well-developed plans to create other wings that could increase support for prisoners and help to motivate positive behaviour. Promising work was being done to increase support for remand prisoners.
- 1.14 While there had been some improvements in activity, time out of cell remained poor outside of Trinity unit and the regime was still too unpredictable in all parts of the prison. Although there were increasing numbers of activity spaces, they were still insufficient for the population.

- 1.15 There had been a great deal of positive activity since the inspection, resulting in some early progress. However, improvements remained limited and fragile, and it was clear that outcomes across many areas were still concerning. The governor was realistic about the scale of the challenges that remained ahead and was making steady progress.

**Charlie Taylor**

HM Chief Inspector of Prisons

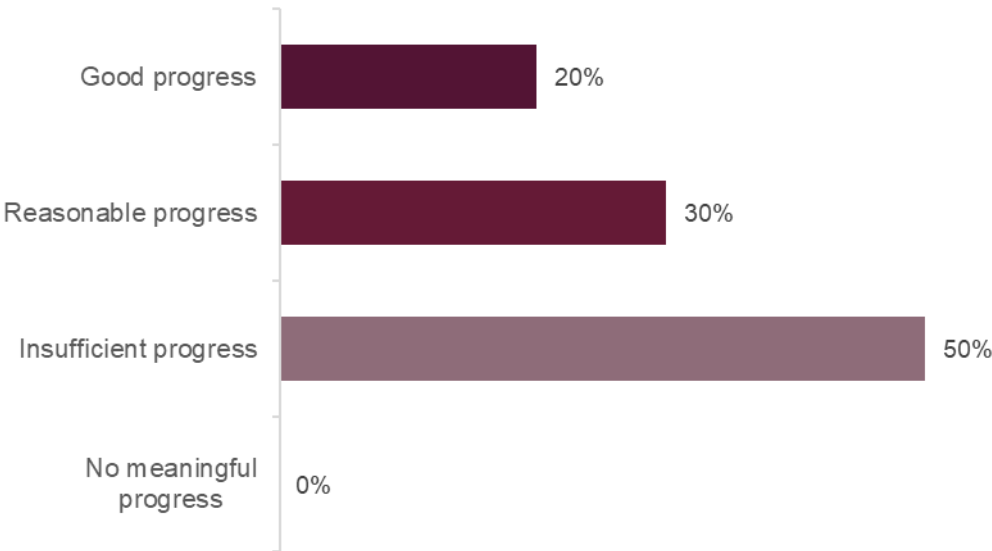
April 2025

## Section 2 Key findings

- 2.1 At this IRP visit, we followed up 10 concerns from our most recent inspection in May 2024 and Ofsted followed up five themes.
- 2.2 HMI Prisons judged that there was good progress in two concerns, reasonable progress in three concerns and insufficient progress in five concerns.

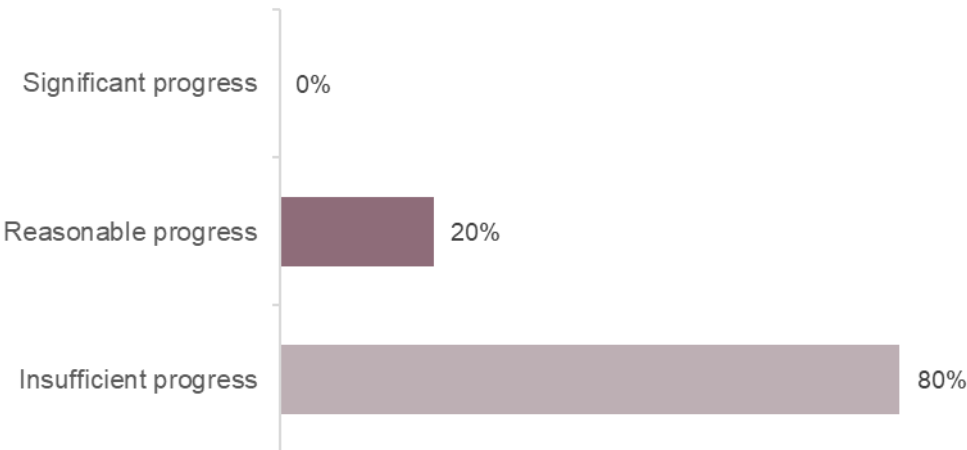
**Figure 2: Progress on HMI Prisons concerns from May 2024 inspection (n=10)**

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



- 2.3 Ofsted judged that there was reasonable progress in one theme and insufficient progress in four themes.

**Figure 3: Progress on Ofsted themes from May 2024 progress monitoring visit (n=5).**



**Notable positive practice**

2.4      We define notable positive practice as:

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

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

Examples of notable positive practice

a)	The prison’s communications team had translated a wide range of written materials. It was also using artificial intelligence (AI) to disseminate multilingual information in the governor’s voice through prison radio and television.	See paragraph 3.42
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## Section 3 Progress against our concerns and Ofsted themes

The following provides a brief description of our findings in relation to each concern followed up from the full inspection in 2024.

### Leadership

**Concern: Inexperience across every grade of operational staff made it difficult to bring about much-needed change or sustain any progress.**

Most leaders were temporarily promoted, and new staff were learning from inexperienced frontline managers. Senior leaders were not visible on the wings.

- 3.1 There had been some improvement in staff experience and capability, with support and mentoring from experienced detached duty staff and the His Majesty's Prison and Probation Service (HMPPS) standards coaching team. After the last inspection, the latter team had delivered a high number of individual and group coaching sessions over a period of three months. These sessions covered issues such as the basic tasks of an officer and professional conduct. Since January 2025, further HMPPS assistance had been provided by the Prison Performance Support Programme, which had a continued focus on upskilling staff and building capability.
- 3.2 Most of the senior leadership team were now substantive in post and developing a more collaborative approach across the different departments. However, despite numerous recruitment campaigns, there was still a high number of temporarily promoted senior officers and custodial managers.
- 3.3 Prisoners and staff told us that some competent custodial managers were making a positive difference to the culture and operation of the wings. However, too many managers had little visibility and provided insufficient support and oversight of officers. Visibility on the wings from senior leaders was also inconsistent but had started to improve.
- 3.4 We considered that the prison had made reasonable progress in this area.



## Encouraging positive behaviour

### **Concern: Levels of violence, particularly against staff, were high.**

Leaders had not taken effective action to address the causes of violence. They had not set and enforced high standards and there was nothing in place that meaningfully incentivised good behaviour.

- 3.5 At the last inspection, violence had increased. Our inspection report described the 'chaotic and confusing' nature of life in the prison as one factor in the level of violence. There was now a calmer and more controlled atmosphere. Effective measures had also been taken to strengthen the safety team and to foster better joint working across all aspects of behaviour management, including security. New leaders brought in since the inspection were playing a large part in this change of management culture.
- 3.6 Joint working included targeted use of the challenge, support and intervention plan (CSIP) system (see Glossary) to support the most challenging prisoners as part of a range of strategies. These included specialist key working by safety officers and a number of imaginative and impactful gang-related interventions delivered or commissioned by Catch 22 (see Glossary). The role of conflict resolution peer mentors was being developed, with two on each wing who were receiving training on mediation from Catch 22.
- 3.7 Since the inspection, the number of assaults had been reducing steadily and was now around half the level we saw then. However, while the reduction in assaults on staff had been continuing, the reduction in assaults on prisoners had stalled in the last four months.
- 3.8 There had been a promising start in creating a positive community feel on the Trinity unit wings. These wings were now reserved for those who were in employment or education, or actively seeking to be so. Plans were also being advanced to set up more possibilities for progression. D wing was due to house prisoners at different stages of progress towards remaining drug-free. One of the Trinity wings was also being turned into a 'reform' unit based on the model of small Scandinavian prisons. However, a recent relaunch of the incentives scheme remained essentially traditional, and the additional visits on offer had little value for almost half of the population.
- 3.9 We considered that the prison had made good progress in this area.

## Security

**Concern: The availability and use of illicit drugs were widespread and presented a significant risk to stability and safety.** Leaders had not allocated sufficient resource to drug testing, or addressed the main issues that fuelled the demand for drugs: poor living conditions, a lack of purposeful activity and ineffective staff-prisoner relationships.

- 3.10 Drone incursion was an acute problem, although good cooperation from the police had led to multiple arrests disrupting the supply chain outside the prison.
- 3.11 Random drug tests were now consistently carried out at the required rate, and the rate of positive random drug tests was high at 37%. Suspicion-based testing was increasing from a low base and had very recently begun to be delivered daily.
- 3.12 Cell windows throughout the establishment were vulnerable to the delivery of contraband by drone. A replacement programme had been agreed, but it was due to take approximately five years to complete.
- 3.13 Prisoners and staff told us that the profile (and smell) of drugs was less conspicuous now. They attributed this in part to a reduction in boredom due to slightly more access to work and time out of cell.
- 3.14 Leaders had begun to get a much better grip on understanding and responding to the changing face of the illicit drug economy in the prison. 'Under the influence' incidents were now being consistently reported and responded to. Close working between health care, security, the safety team and Change, Grow, Live (providing social care) was also now playing an important part in a whole-prison approach.
- 3.15 Other aspects of drug strategy were better coordinated. However, gate security was still potentially vulnerable, partly due to the cramped space available and partly owing to a lack of staff competence and consistency.
- 3.16 We considered that the prison had made insufficient progress in this area.

## Suicide and self-harm prevention

**Concern: Rates of self-inflicted deaths and self-harm were high and rising.** Oversight did not identify or fully address the drivers of self-harm. Despite seven self-inflicted deaths in the last year, the death in custody action plan had not been reviewed to make sure that all actions were addressed promptly.

- 3.17 Since the full inspection there had been four deaths, two of which were self-inflicted and one which was classified as other non-natural. Prisoner and Probation Ombudsman (PPO) reports had not yet been completed for the self-inflicted deaths. However, early learning reviews had taken place and a number of actions had been implemented to improve practices.
- 3.18 Leaders now maintained good oversight of the death in custody action plan detailing recommendations raised in PPO investigations reports into previous deaths and the findings of coroners' Prevention of Future Death reports. However, many concerns raised, including weaknesses in the ACCT process (see Glossary) and in the use of emergency codes, had not yet been fully rectified. There had been some improvement in the response times to emergency call bells. Managers had good oversight of these but there were still frequent delays.
- 3.19 Since the last inspection, the rate of self-harm had reduced by 28%. Serious self-harm incidents requiring hospital attendance were also lower and on a clear downward trend. The use and overall length of constant supervision had also decreased.
- 3.20 The monthly safety meeting and weekly safety assurance and safety intervention meetings reviewed relevant data and there was a good understanding of the drivers of self-harm and emerging issues. Most self-harm involved prisoners who self-harmed prolifically and stemmed largely from immigration cases, frustrations over access to the regime and phones to maintain family contact. The key worker model had been reconfigured to meet the needs of the most vulnerable prisoners, who required additional support.
- 3.21 Despite quality assurance processes for ACCT case management, this did not always demonstrate effective support. For example, care plans continued to be sparse and there was a lack of detail about day-to-day recording. ACCT reviews continued to be conducted in busy office areas, which were noisy and lacked privacy. However, plans were in place to create a dedicated discrete space where these could be held.
- 3.22 We considered that the prison had made reasonable progress in this area.

## Staff-prisoner relationships

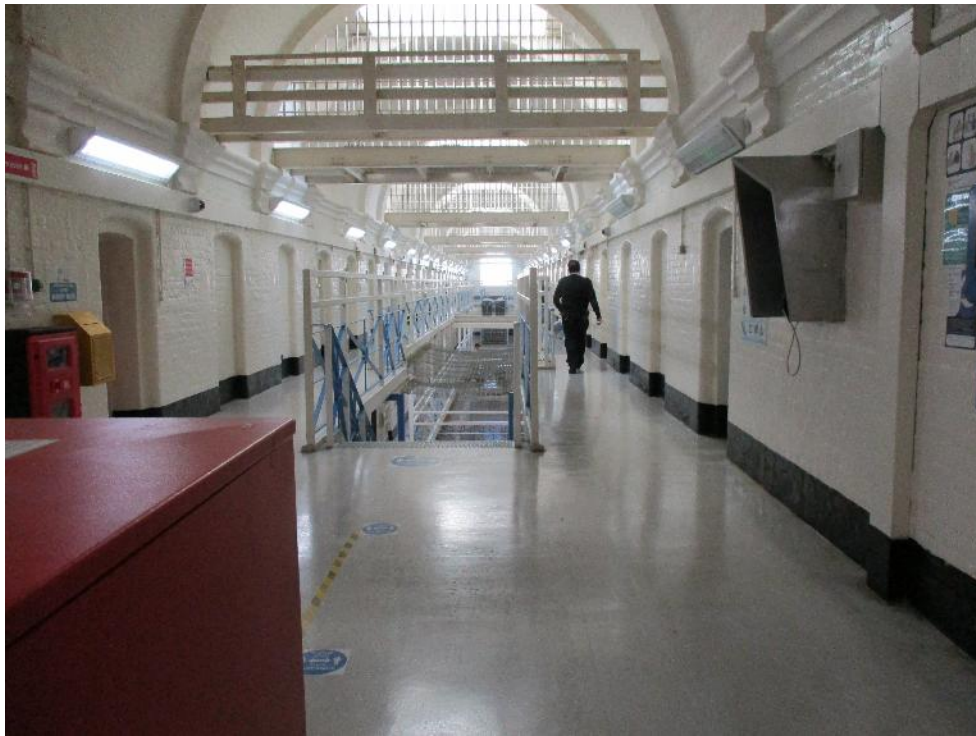
**Concern: Staff-prisoner relationships were distant and ineffective.** The lack of any key work hindered opportunities to develop more productive relationships. Staff absences and inexperience meant that prisoners struggled to get even basic requests dealt with.

- 3.23 Staff-prisoner relationships on Trinity unit had improved, helping to create a positive community feel. We observed good engagement and conversations on the unit, including involvement in wing activities such as pool and table tennis, and staff were much more visible. There were plans in place for these good practices to be developed on other wings.
- 3.24 Elsewhere in the prison, relationships remained distant and prisoner feedback was more negative. There were numerous reports of dismissive or rude staff. We saw evidence of basic requests not being dealt with, which caused frustration among prisoners.
- 3.25 Since the inspection, staff experience had improved slightly and leaders had started some initiatives to further improve relationships and culture. This included plans to introduce specialist wings later in the year (see paragraph 3.8).
- 3.26 There had been good progress in reducing the number of unauthorised staff absences. However, due to sickness, restricted duties or training, a third of officers were still not available for operational duty on any given day.
- 3.27 Key work had started in the last few months and training had been delivered to a dedicated group of staff. Prisoners with complex needs were prioritised and few people were currently receiving keywork. The sessions varied in quality and regularity.
- 3.28 We considered that the prison had made insufficient progress in this area.

## Living conditions

**Concern: The condition of cells and prison facilities was poor.** Most cells had missing items or damaged furniture and fittings. Many cells and communal areas were dirty and dilapidated. Showers were in poor condition and there were frequent problems with heating and hot water.

- 3.29 Communal areas were in considerably better condition. The long-established problem of rats and other vermin had also been addressed to reasonably good effect.



**Cleaner landing**

- 3.30 Many of the small and overcrowded cells remained in poor condition, with broken furniture, but problems were being addressed more systematically. There were regular management checks, dedicated 'decency officers' and a daily prisoner work party. Graffiti remained a problem and this was not being addressed with sufficient rigour.



**K wing refurbishment**



- 3.31 Many prisoners told us about problems with heating and hot water supply, which had persisted for some time despite efforts to replace boilers. Many of the shower rooms were also in poor condition and, due to a lack of ventilation, mould often quickly returned after repainting. A partial refurbishment programme had begun.



**Shower**

- 3.32 Living conditions on Trinity unit had improved considerably. Prisoners were now motivated to keep the environment clean and tidy due to a desire to stay in a more congenial atmosphere than that of Heathfield unit.
- 3.33 We considered that the prison had made insufficient progress in this area.

### **Prisoner consultation, applications and redress**

**Concern: Processes designed to help prisoners resolve problems, manage their daily life and contribute to the prison community were not operating effectively.** There were, for example, significant weaknesses in the complaints, applications and consultation processes.

- 3.34 Many prisoners reported an ongoing lack of confidence in the complaints and applications procedures. Applications, which were submitted through electronic kiosks, were not monitored for timeliness of responses. However, staff had made particular efforts to improve the response to property problems, which was a common concern for prisoners.

- 3.35 Leaders had improved systems for the collection, tracking and quality assuring of complaints. Complaint response times had improved but were often still too long, with one prisoner in our sample waiting 57 days to receive a response. Most complaints were responded to appropriately, but the quality assurance process had identified some that were unhelpful and dismissive. Some limited trend analysis of complaints had been conducted, but there continued to be no independent oversight of them.
- 3.36 Prisoner consultation had improved with regular, useful and well-attended monthly prisoner council meetings. The prison radio station (Radio Wanno) was used effectively to communicate improvements introduced from these consultations. Wing forums were well embedded on Trinity unit and they were in the early stages of being introduced across other parts of the establishment.
- 3.37 We considered that the prison had made insufficient progress in this area.

## Fair treatment and inclusion

**Concern: The provision for foreign national prisoners, who made up around half the population, was too limited.** There were too few spaces in English for speakers of other languages classes, professional interpreting services and translated materials were not used routinely and the reducing reoffending strategy did not seek to meet the needs of these prisoners.

- 3.38 Foreign national prisoners were now identified as a priority cohort in the prison and were included in the reducing reoffending strategy. There was a separate foreign national strategy, supported by regular meetings to oversee provision. Focus groups were being delivered, but discussions and actions from these meetings were not documented or followed up.
- 3.39 Catch 22 had continued to deliver a good support service to foreign national prisoners, but the contract was coming to an end imminently with no immediate replacement. This was likely to significantly reduce the support available to this group, although two foreign national specialist officers were being recruited and due to start in the coming months. Prison leaders had undertaken to continue the coffee morning that Catch 22 ran twice a month for foreign national prisoners who were not receiving visits.
- 3.40 The Home Office team was still understaffed and unable to provide wing surgeries. Bail for Immigration Detainees provided ad hoc support when requested, but had not been contacted during the previous three months.
- 3.41 English for speakers of other languages (ESOL) courses now had an additional two classes available for vulnerable prisoners, although waiting lists were still significant.

- 3.42 There was a significant amount of information translated into 23 languages on the wing kiosks. The prison radio and TV stations also had translated information available in the top six languages, including governor's notices. The library had an increased stock of foreign national books, although some legal texts were out of date.



**Radio Wanno**

- 3.43 There were a number of multilingual staff. However, the use of professional interpretation remained low and was not always used when needed, for example during an ACCT review.
- 3.44 We considered that the prison had made reasonable progress in this area.

## **Time out of cell**

**Concern: Time out of cell was poor and unpredictable.** Most prisoners were locked up for over 22 hours a day. Prisoners often missed important appointments and were unable to collect critical medication, which posed serious potential risks to health. Prisoners struggled to complete basic tasks, shower and exercise in the short time they were unlocked.

- 3.45 In August 2024, a new core day had been introduced to allow more predictable exercise on alternate days. This was improved to five days a week shortly before our visit. However, while delivery of the published regime was now more consistent, it was still unpredictable. This was partly due to staff shortages and partly because staff were still unable to account for all prisoners. As at the inspection, we attempted to conduct two roll checks but had to abandon them as staff could not provide accurate numbers or confirm where prisoners were located.
- 3.46 While the number of activity places had increased (see paragraph 3.49), unemployed prisoners, who comprised around 58% of the population, could still spend only two hours out of their cell a day. However, the regime on Trinity unit had significantly improved, and they were unlocked for most of the core day.



- 3.47 Processes had been introduced to monitor the collection of medication, and this had improved since the inspection.
- 3.48 We considered that the prison had made insufficient progress in this area.

## Education, skills and work



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

**Theme 1:** There were not enough purposeful activity spaces to occupy prisoners and help them to develop new skills and knowledge.

- 3.49 Since the last inspection, leaders and managers had increased education, skills, and work (ESW) activity spaces significantly. The prison achieved this by increasing the number of spaces in existing industrial workshops and through the creation of new wing jobs (particularly wing representatives and wing recycling roles). Leaders had achieved this expansion despite the limitations of the physical resources at the prison.
- 3.50 A new education curriculum was rolled out in the week of this inspection, which offered further activity spaces. Almost all education courses were now delivered over a maximum of six weeks duration. This was appropriate to facilitate regular access to education for the great majority of the population, considering the high levels of population turnover in this busy reception prison.
- 3.51 Allocation rates across ESW were regularly below the maximum capacity of the activity, which resulted in too much valuable purposeful activity resource remaining unused. Staff had been too slow to identify prisoners who persistently refused to attend and to replace them with those on the waiting lists. In addition, too many education classes were cancelled due to staff absence, thereby depleting the already stretched purposeful activity resource available to prisoners.
- 3.52 Despite the additional purposeful activity places now available, there were still only sufficient spaces for just over half of the available population and too many prisoners were unemployed.
- 3.53 Ofsted considered that the prison had made insufficient progress against this theme.

**Theme 2:** Prisoners' attendance at the activities offered was far too low. Prisoner pay did not incentivise engagement in education and too many activities lacked relevance to prisoners' needs.

- 3.54 Prisoner attendance in education continued to be poor with less than half of those allocated a place attending. Attendance in prison industries was better but was still not high enough. Neither had shown any improvement since the last inspection.
- 3.55 Leaders and managers had tried to address this problem and had reviewed the prisoner pay policy twice in the past year. Following the review, attendance to education now attracted the second highest level of pay in the prison and pay no longer acts as a disincentive to engagement.
- 3.56 In addition, leaders and managers had also conducted prisoner needs analysis biannually. They had used this information, along with labour market intelligence, to refresh the curriculum to make it more relevant to the needs and interests of prisoners.
- 3.57 The prison had also reviewed the allocations policy and sought to improve the induction process by using prisoner representatives to help ensure that prisoners were placed in the right activity as quickly as possible.
- 3.58 Leaders had also highlighted the positive impact that the new governor had had on raising the priority of improving attendance to ESW. They reported that increased scrutiny of attendance levels took place at daily meetings where the reasons for absence were challenged. It was, however, too early to see the impact of this increased focus.
- 3.59 Prisoner absences due to legal visits, primary health care appointments, and prisoner illness were well controlled and accounted for few absences. However, too many absences continued. The overwhelming majority of these were either due to prisoners refusing to attend – many so that they could access a wing-based regime during the core day – or because of education closures due to staff absences.
- 3.60 Ofsted considered that the prison had made insufficient progress against this theme.

**Theme 3:** The prison's quality improvement group for education, skills and work, and its associated quality improvement planning, did not have sufficient involvement from senior leaders in the prison. This prevented the group from functioning effectively as a key driver for change and improvement.

- 3.61 Attendance at the quality improvement group (QIG) by the senior management team had improved significantly immediately after the last inspection. Similarly, the new governor and deputy governor provided a

strong lead in the drive to improve ESW. They had helped raise its status and had encouraged the development of a healthier culture where ESW priorities were better embedded into the daily routines of the prison.

- 3.62 Though now better attended and improved, the QIG meeting still lacked impact in the drive for quality improvement planning and delivery. Following the last inspection, it had focused heavily on developing an improved teamworking culture that had been largely absent. However, the QIG meetings still lacked structure and purpose. There was no shared vision of what improvements they wanted to achieve; there was no clear action plan to drive the changes they sought. Too many previous actions were either ongoing or lacked impact. Leaders and managers recognised this and were now focused on the next phase of their development which was to produce smarter actions that were necessary to drive swifter progress. They also recognised the need to review the impact of their actions and to ensure that they measured accurately the benefit to prisoners of their work.
- 3.63 Ofsted considered that the prison had made insufficient progress against this theme.

**Theme 4:** There was a substantial backlog of uncompleted personal learning plans because too few information, advice and guidance sessions took place during the education, skills, and work induction. This meant that staff had poor records of prisoners' starting points, career aims or support needs in and outside of custody.

- 3.64 The service provider commissioned by the prison to complete personal learning plans (PLPs) had carried staffing vacancies for too long and had only recently become fully staffed. The prison's leaders and managers had focused this new resource on reducing the number of prisoners without PLPs and as such, the backlog of incomplete PLPs was improved but was still too high. Leaders could not provide PLPs for any prisoners on the random sample chosen by inspectors.
- 3.65 Too many completed PLPs lacked analysis of the skills, knowledge or experiences the prisoners had gained prior to reception. Neither did they adequately address short or long-term planning goals or plan the sequencing of activities going forward. As such, the PLPs had insufficient impact in supporting prisoners to make the most of their time in custody.
- 3.66 A significant minority of prisoners chose not to attend their induction sessions. This resulted in prisoners applying to engage in activities without knowing the full range of available options or having had impartial advice on which pathways would best support their short and long-term goals.
- 3.67 Currently, allocations staff did not use the information on PLPs when making decisions about where to place prisoners. They did not take any account of what would best suit the prisoners. Instead, prisoners

applied for activities via the wing-based kiosks and staff allocated on a first come first served basis.

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

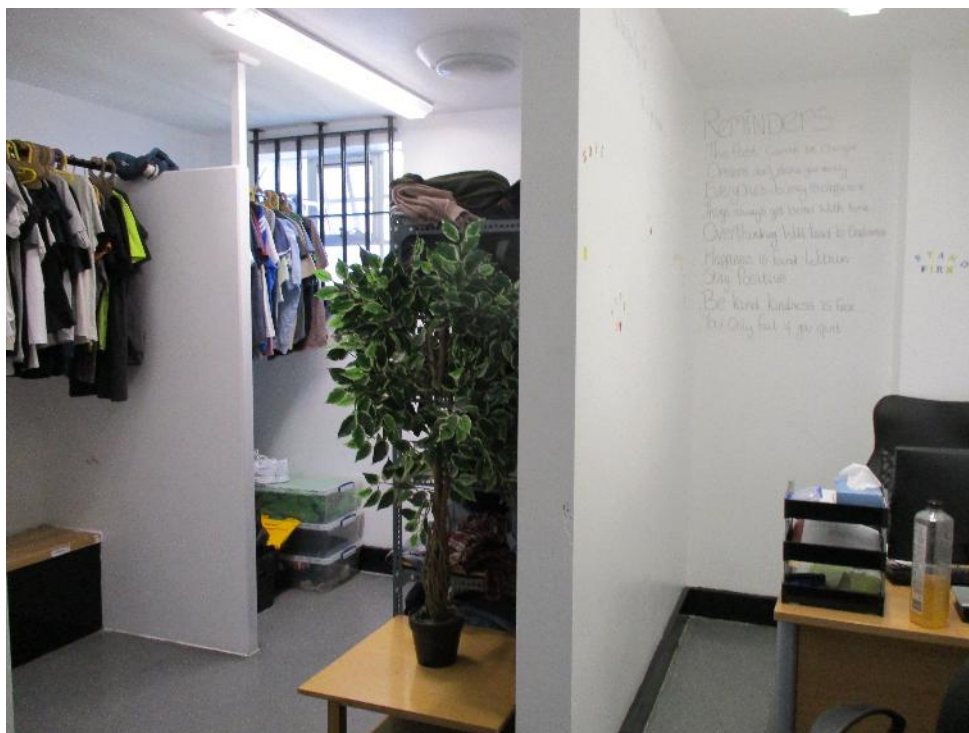
**Theme 5:** The quality of teaching and learning in education and prison workshops required improvement.

- 3.69 Leaders and managers took prompt action to improve the quality of teaching and training. In education, they appointed new staff, supported those who needed to improve and provided update training about the craft of teaching for all. In prison industries, managers provided refresher training for instructors and set up peer support arrangements for those who needed additional help.
- 3.70 There had been an improvement in teaching since the last inspection, particularly regarding the management of prisoner behaviour in sessions. However, the quality of teaching varied too much and further improvements were needed, particularly in English as a second language (ESOL), where the pace of learning was often too fast.
- 3.71 In prison industries, targets set by instructors in the progress in workshops booklets were often too broad or missing. Staff had not involved prisoners sufficiently well in the target setting process and some prisoners did not recognise the booklets or could not explain how the booklets helped support or focus their learning.
- 3.72 Education and industries leaders had carried out frequent lesson visits to check the quality of teaching and tutor and learner files. In education, tutors had received useful feedback from these visits that had helped them to improve their teaching. Tutors knew their areas of strength and the areas they should improve.
- 3.73 Most prisoners had learned new knowledge, skills, and behaviours in ESW activities and tutors created a purposeful atmosphere, which was conducive to learning. Prisoners were respectful and they worked well together. They were confident at sharing their answers within the class and talking about what they had learned. Many had developed important skills for their personal development such as being patient and listening to others.
- 3.74 Leaders had introduced shorter courses in ESOL and English which suited the high proportion of prisoners with short stays at the prison and these had contributed to an increase in the number of prisoners who remained on their courses. Almost all prisoners who completed courses in these subjects now achieved them.
- 3.75 Ofsted considered that the prison had made reasonable progress against this theme.

## Returning to the community

**Concern: Resettlement and pre-release support for unsentenced prisoners was poor.** This was despite remand and unsentenced prisoners making up more than half the population.

- 3.76 Following the full inspection, a well-regarded remand support service was reinstated. In the six months before our review, the service had helped to support over 1,000 unsentenced prisoners with areas such as debt management, gaining legal representation and housing support. It also oversaw 12 prisoner remand representatives, who had received peer mentor training. A new provider had been awarded a 12-month contract for this service, which included a new element of support in the community following release. However, there was due to be a short gap between service providers.
- 3.77 There were now four permanent bail officers based at the prison and they were offering a good service to those who required it. There was still no formal finance or debt support, but the prison had just been chosen to take part in a pilot for a new debt advice service to be delivered via an electronic tablet.
- 3.78 St Mungo's housing support for remand prisoners had increased, along with their staffing numbers. There was not, however, any reliable data on the housing outcomes for this cohort.
- 3.79 During our visit, a new 'Leavers Lounge' had opened to help address immediate practical concerns before release. Support included providing clothes, travel information, access to foodbank vouchers, and contacting families and professionals. This was a promising service in its early stages of development.



**Leavers Lounge**

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



## Section 4 Summary of judgements

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

### **HMI Prisons concerns**

Inexperience across every grade of operational staff made it difficult to bring about much-needed change or sustain any progress. Most leaders were temporarily promoted, and new staff were learning from inexperienced frontline managers. Senior leaders were not visible on the wings.

#### **Reasonable progress**

Rates of self-inflicted deaths and self-harm were high and rising. Oversight did not identify or fully address the drivers of self-harm. Despite seven self-inflicted deaths in the last year, the death in custody action plan had not been reviewed to make sure that all actions were addressed promptly.

#### **Reasonable progress**

Levels of violence, particularly against staff, were high. Leaders had not taken effective action to address the causes of violence. They had not set and enforced high standards and there was nothing in place that meaningfully incentivised good behaviour.

#### **Good progress**

The availability and use of illicit drugs were widespread and presented a significant risk to stability and safety. Leaders had not allocated sufficient resource to drug testing, or addressed the main issues that fuelled the demand for drugs: poor living conditions, a lack of purposeful activity and ineffective staff-prisoner relationships.

#### **Insufficient progress**

Time out of cell was poor and unpredictable. Most prisoners were locked up for over 22 hours a day. Prisoners often missed important appointments and were unable to collect critical medication, which posed serious potential risks to health. Prisoners struggled to complete basic tasks, shower and exercise in the short time they were unlocked.

#### **Insufficient progress**

Staff-prisoner relationships were distant and ineffective. The lack of any key work hindered opportunities to develop more productive relationships. Staff absences and inexperience meant that prisoners struggled to get even basic requests dealt with.

#### **Insufficient progress**

The condition of cells and prison facilities was poor. Most cells had missing items or damaged furniture and fittings. Many cells and communal areas were dirty and dilapidated. Showers were in poor condition and there were frequent problems with heating and hot water.

#### **Insufficient progress**

Processes designed to help prisoners resolve problems, manage their daily life and contribute to the prison community were not operating effectively. There were, for example, significant weaknesses in the complaints, applications and consultation processes.

#### **Insufficient progress**

The provision for foreign national prisoners, who made up around half the population, was too limited. There were too few spaces in English for speakers of other languages classes, professional interpreting services and translated materials were not used routinely and the reducing reoffending strategy did not seek to meet the needs of these prisoners.

#### **Reasonable progress**

Resettlement and pre-release support for unsentenced prisoners was poor. This was despite remand and unsentenced prisoners making up more than half the population.

#### **Good progress**

### **Ofsted themes**

There were not enough purposeful activity spaces to occupy prisoners and help them to develop new skills and knowledge.

#### **Insufficient progress**

Prisoners' attendance at the activities offered was far too low. Prisoner pay did not incentivise engagement in education and too many activities lacked relevance to prisoners' needs.

#### **Insufficient progress**

The prison's quality improvement group for education, skills and work, and its associated quality improvement planning, did not have sufficient involvement from senior leaders in the prison. This prevented the group from functioning effectively as a key driver for change and improvement.

#### **Insufficient progress**

There was a substantial backlog of uncompleted personal learning plans because too few information, advice and guidance sessions took place during the education, skills and work induction. This meant that staff had poor records of prisoners' starting points, career aims or support needs in and outside of custody.

#### **Insufficient progress**

The quality of teaching and learning in education and prison workshops required improvement.

#### **Reasonable progress**



## Appendix I About this report

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

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

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

The aims of IRPs are to:

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

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each concern we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in May 2024 for further detail on the original findings (available on our website at [Our reports – HM Inspectorate of Prisons \(justiceinspectorates.gov.uk\)](https://justiceinspectorates.gov.uk)).

### IRP methodology

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

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

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

**No meaningful progress**

Leaders had not yet formulated, resourced or begun to implement a realistic improvement plan to address this concern.

**Insufficient progress**

Leaders had begun to implement a realistic improvement strategy (for example, with better and embedded systems and processes), but prisoner outcomes were improving too slowly or had not improved at all.

**Reasonable progress**

Leaders were implementing a realistic improvement strategy, with evidence of sustainable progress and some early improvement in outcomes for prisoners.

**Good progress**

Leaders had already implemented a realistic improvement strategy to address this concern and had delivered a clear improvement in outcomes for prisoners.

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

**Insufficient progress**

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

**Reasonable progress**

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

**Significant progress**

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

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

## **Inspection team**

This independent review of progress was carried out by:

Hindpal Singh Bhui	Team leader
Martin Kettle	Inspector
Chelsey Pattison	Inspector
Fiona Shearlaw	Inspector
David Everett	Ofsted inspector
Montserrat Perez	Ofsted inspector

## Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find.

### **ACCT**

Assessment, care in custody and teamwork – case management for prisoners at risk of suicide or self-harm.

### **Catch 22**

Catch 22 is a registered charity providing a range of support services in prisons and in the community. In prisons, its aim is to provide long-term support to prisoners, to promote positive outcomes and reduce reoffending.

### **Challenge, support and intervention plan (CSIP)**

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

### **Key worker scheme**

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

### **Leader**

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

### **Mandatory drug testing (MDT)**

Enables prison officers to require a prisoner to supply a urine sample to determine if they have used drugs.

### **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.

### **Prisons and Probation Ombudsman (PPO)**

Independent organisation investigating deaths in custody, and complaints from people who are in custody or under community supervision.

**Social care package**

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

**Time out of cell**

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.

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

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

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