Report on an unannounced inspection of

HMP Lowdham Grange

by HM Chief Inspector of Prisons

3–14 March 2025

Contents

Introduction

Situated on the outskirts of Nottingham, Lowdham Grange is a category B training prison which can hold up to 888 adult men. Nearly all prisoners are serving long sentences, including life, and many present a very serious risk of harm. From 1998 until August 2023, the prison was operated by Serco on a 25-year contract. After this period, a new private contractor, Sodexo, took over. However, the handover was mismanaged and the new contractor failed to deliver on its commitments. This led to the prison being brought under the direct management of HM Prison and Probation Service (HMPPS) in August 2024.

When we inspected in May 2023, leaders were three months into a complex and difficult transition between contractors and our judgements reflected this. In safety, respect, and preparation for release we judged outcomes for prisoners to be not sufficiently good, and in purposeful activity we judged them to be poor. At a follow up review of progress in early 2024, not much had changed and some areas were arguably even worse.

At this inspection, we found outcomes in safety and respect to be poor, and not sufficiently good in purposeful activity and preparation for release. Ultimately, I decided against issuing an Urgent Notification to the Secretary of State because HMPPS was already aware of the failings at Lowdham Grange and was providing significant ongoing support. A new governor had recently arrived and had a clear sense of the challenges and of the seriousness of the concerns that we had identified.

In our survey, 40% of prisoners said that they currently felt unsafe. The level of violence had increased since the last inspection and use of force had trebled. The rate of self-harm, although on a downward trajectory over the past 12 months, was still the third highest among category B trainers and 39% higher than in our 2023 inspection. Work to incentivise prisoners was almost non-existent and formal disciplinary procedures were in disarray. The random drug testing positive rate was 40.6% for the previous 10 months and 56% of surveyed prisoners said it was easy to get hold of drugs.

The prison’s main strength was the quality of accommodation and the general environment. All prisoners lived in single cells and the prison was not overcrowded. However, staff-prisoner relationships were inadequate. Prisoners were unable to rely on staff, who were poorly supervised and very inexperienced, and key work barely happened. Systems of redress lacked accountability and therefore credibility, and work to promote fairness was poor. Inadequate leadership and staff shortages had led to some of the worst health care provision inspectors had seen in recent years.

Time out of cell was often curtailed or delivered inconsistently and during our roll checks we found 43% of prisoners locked in their cells during the working day. While there were some early signs of improvement in the provision of education, skills and work, the jail was fundamentally failing to fulfil its purpose as a category B training establishment and just 39% of surveyed prisoners told us that their experience in the prison would reduce their likelihood of reoffending. Offender management caseloads were high and contact between

prisoners and offender managers was only triggered by key events such as parole. Even though most prisoners were from a different resettlement area and could not move closer to home, work to promote family ties was underdeveloped.

Although there were many challenges at Lowdham Grange, the new governor had quickly established an understanding of the key issues that needed to be addressed, and inspectors left with some hope that the chaos seen at recent visits had started to subside. To maintain this momentum, the governor will need continued support to rebuild her senior team, better equip middle managers and develop a cohort of staff capable of delivering basic standards.

Charlie Taylor
HM Chief Inspector of Prisons
May 2025

What needs to improve at HMP Lowdham Grange

During this inspection we identified 15 key concerns, of which five 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. **The use of force had risen substantially and was very high. Governance and oversight were poor.**

2. **The rate of self-harm was high and the response to death in custody recommendations was inadequate.** There had been two self-inflicted deaths in the previous two years and support for those at risk of self-harm was weak.

3. **Middle managers were not providing sufficient visible leadership on residential units to a staff group that contained many inexperienced officers.**

4. **Health services were unsafe. Ineffective clinical governance, inconsistent leadership, inadequate staffing and extremely long waits for primary care were leading to very poor outcomes.**

5. **Leaders' failure to deliver a reliable regime meant that prisoners often could not complete domestic tasks or reach education and work on time.** Attendance at mathematics and English courses was particularly low.

Key concerns

6. **Reception and first night risk assessments were not always completed or sufficiently thorough when they were done.**

7. **The adjudication process was poorly managed and lacked credibility among prisoners.** Many charges were not brought to a conclusion and there was a lack of oversight and quality assurance.

8. **The regime, conditions and oversight structures in the segregation unit were not good enough.**

9. **Despite some recent improvements to security, too many illegal drugs were coming into the prison and in the previous two years there had been four deaths attributable to problematic drug use.**

10. **Prisoner complaints and applications systems were not working effectively and consultation opportunities were limited.**

11. **The promotion of fair treatment and inclusion was poor and it was especially concerning to find some prisoners with disabilities living in neglectful conditions.**

12. **Too few prisoners achieved qualifications in mathematics or received adequate careers advice and guidance.** There was also an inadequate curriculum for prisoners who did not speak English as a first language.

13. **Prisoners were not being supported adequately to maintain family ties. The shambolic visits booking system was a particular hindrance to family contact.**

14. **Prisoners did not have enough opportunity to demonstrate risk reduction or learn skills to prepare them for release; sentence progression was hindered by the lack of meaningful face-to-face contact with prison offender managers.**

15. **Release planning was undermined by poor communication between prison and community offender managers and some prisoners close to release did not have the necessary risk management plans in place.**

About HMP Lowdham Grange

Task of the prison/establishment
HMP Lowdham Grange is a men's category B training prison.

Certified normal accommodation and operational capacity (see Glossary) as reported by the prison during the inspection
Prisoners held at the time of inspection: 836
Baseline certified normal capacity: 888
In-use certified normal capacity: 888
Operational capacity: 888

Population of the prison
- 97% were serving a sentence of over four years.
- 38% had indeterminate sentences.
- 48% of prisoners from minority ethnic backgrounds.
- 113 foreign national prisoners.
- 275 new prisoners received in 2024.
- 77 prisoners released into the community in the 12 months to 31 January 2025.
- 81 prisoners waiting for transfer to category C or category D prisons.

Prison status (public or private) and key providers
Public

Physical health provider: Nottinghamshire NHS Foundation Trust
Mental health provider: Nottinghamshire NHS Foundation Trust
Substance misuse treatment provider: Nottinghamshire NHS Foundation Trust
Dental health provider: Time For Teeth/Nottinghamshire NHS Foundation Trust
Prison education framework provider: Novus
Escort contractor: GeoAmey

Prison group
Long-term high security estate

Prison group director
Gavin O'Malley

Brief history
HMP Lowdham Grange opened in 1998 and was operated by Serco Justice on a 25-year contract until August 2023 when Serco lost the contract to Sodexo. Sodexo operated the prison exclusively from August 2023 until August 2024, when HMPPS 'stepped in' by taking over operational running of the site in support of Sodexo, because of safety and security concerns. From August 2024, the establishment has been fully operated by HMPPS with no private provider presence on site.

The prison has been operated as a category B training prison since opening in 1998. The original prison was opened with two houseblocks; in 2007, two further houseblocks were added, and houseblock five was opened in 2009.

Short description of residential units
There are five houseblocks, each containing between two and four wings. Each wing has approximately 65 cells. All wings house general population apart from H wing, which is the induction wing, and P wing, which houses prisoners on the enhanced level of the incentives scheme. The segregation unit contains 25 beds.

Name of governor and date in post
Tyrienna Greenslade, 3 March 2025

Changes of governor/director since the last inspection
John Hewitson (Serco): February 2023 – August 2023
Martin Booth (Sodexo): August 2023 – October 2023
Damian Evans (Sodexo): October 2023 – August 2024
Neil Thomas (HMPPS): August 2024 – February 2025

Independent Monitoring Board chair
John Andrews

Date of last inspection
15–26 May 2023

Section 1 Summary of key findings

Outcomes for prisoners

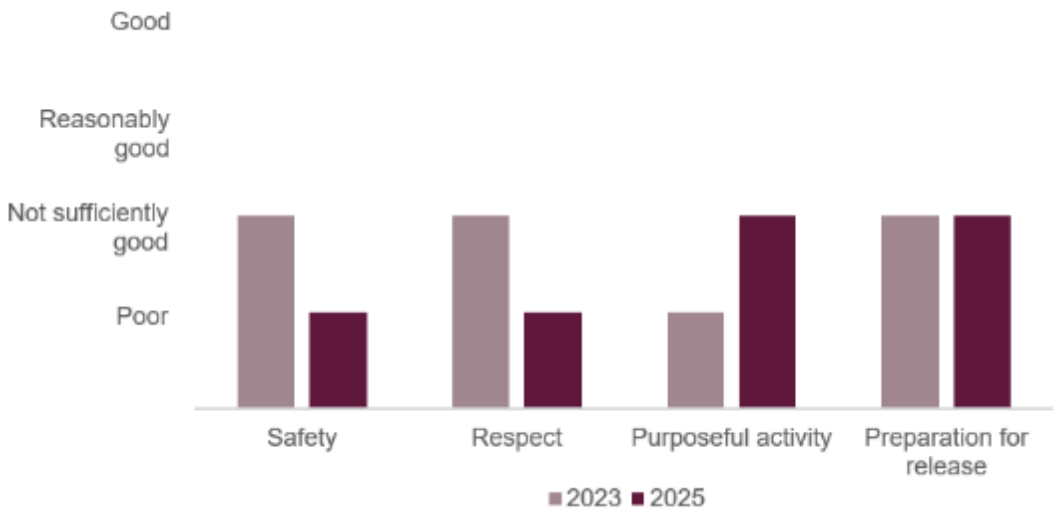
1.1 We assess outcomes for prisoners against four healthy prison tests: safety, respect, purposeful activity, and preparation for release (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

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

- poor for safety
- poor for respect
- not sufficiently good for purposeful activity
- not sufficiently good for preparation for release.

1.3 We last inspected HMP Lowdham Grange in 2023. Figure 1 shows how outcomes for prisoners have changed since the last inspection.

Figure 1: HMP Lowdham Grange healthy prison outcomes 2023 and 2025



Progress on priority and key concerns from the last inspection

1.4 At our last inspection in 2023 we raised 14 concerns, six of which were priority concerns.

1.5 At this inspection we found that two of our concerns had been addressed, three had been partially addressed and nine had not been addressed. Two of the three concerns in purposeful activity had been achieved. However, none of the four concerns raised in respect had been addressed and three of the four safety concerns, including two priority concerns, were not achieved. For a full list of progress against the concerns, 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 two examples 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)	Leaders had developed a media course, which enabled prisoners to develop high-level digital skills and to work with industry-standard software, in line with the latest labour market requirements.	See paragraph 5.11
b)	The offender management unit produced easy-read licence conditions with pictures to help prisoners with learning needs to understand the requirements of being on licence.	See paragraph 6.30

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 Use of data and overall governance were weak in a number of areas and many systems were badly flawed, such as those for complaints, visits and adjudications. New leaders had recently started to develop better processes and there were signs of progress despite continuing poor outcomes. A new governor had just arrived and had a clear sense of the challenges at the prison and of the seriousness of the concerns that we identified. New functional leadership was also starting to make a positive impact on the previously poor levels of direction and communication across the establishment.

2.3 Leaders had not managed the transition, in February 2023, between the different private providers Serco and Sodexo well enough, and this led eventually to such a deterioration in outcomes that HMPPS took over the management of the prison later in 2023. This decision had led to more stability in the prison with, for example, far fewer prisoner protests in recent months. However, improvements were recent and fragile, and many of the problems of resources and confusion about procedures that we saw at the last inspection were only now starting to improve.

2.4 Detached duty and overtime had been used appropriately to reinforce staff numbers, but there were still regular staffing shortfalls, which contributed to frequent regime curtailments. Staff morale was fragile and there was a danger of a poor culture developing and becoming embedded without substantial action to improve leadership support, oversight and accountability. Middle managers were not providing sufficiently visible leadership on the units to support the many inexperienced staff. It was positive that advanced plans were in place to provide a dedicated team of staff mentors.

2.5 Leaders had not shown sufficient drive in tackling longstanding concerns about violence and had not introduced creative measures to motivate positive behaviour. Leaders had allowed the development of a culture of poor accountability for use of force, especially in the segregation unit. New leaders in the unit had started to address poor standards and a negative culture, as well as a chaotic and ineffective adjudication system, with some early success. There was also a more robust and well-organised approach to security, demonstrated by better partnership working with the police and CPS, and more success in finding illicit items.

2.6 There had been an inadequate leadership focus on addressing recommendations following deaths in custody and similar concerns were being identified by successive investigations. There had been very little leadership focus on fair treatment and inclusion, leading to poor outcomes for some prisoners.

2.7 There had been five different heads of health care in the previous two years, leading to inconsistent and fragile leadership. Clinical governance and oversight of health services were inadequate, and health care leaders had not given sufficient attention to patient safety, leading to poor outcomes for some patients.

2.8 In contrast, the dynamic head of education, skills and work had worked determinedly to increase and improve purposeful activity, with notable success. There were also advanced plans to provide enough activity spaces for the whole population.

2.9 Leaders had commissioned new family support provision, which was due to improve delivery in the coming months, but they had allowed a dysfunctional visits system to remain in place for too long.

2.10 There was no reducing reoffending needs analysis or up-to-date strategy in place, and not enough leadership drive to improve this area. However, the introduction of a new senior probation officer had made a positive impact on the offender management unit where oversight and working systems were improving.

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 The prison received an average of 32 new arrivals a month. The reception process was reasonably quick and staff were friendly and supportive. Safer custody staff no longer saw all prisoners on arrival and peer workers were not located in reception to provide immediate support, although this was rectified during the inspection. All prisoners were subject to a body scan and strip-search.

3.2 Holding rooms were bare, with no written information about the prison, and there was nothing to keep new arrivals occupied while they waited.

Reception holding room

3.3 All prisoners received a health care screening in a private room, but the initial safety and vulnerability risk assessment was often not completed by reception staff and immediate first night concerns could have been missed as a result. While induction staff completed a follow-up risk assessment, this was of poor quality, did not take place in private and often did not fully explore issues that were raised. The information gathered was not always communicated to other staff through the NOMIS system.

3.4 New arrivals were collected by induction staff and were given a £2 phone call, a new vape and box of capsules, and a £15 advance to purchase items from the prison shop for their first week. This helped to reduce the risk of prisoners getting into debt on arrival.

3.5 First night cells were clean and in good condition and all had essential items like curtains, new bedding, kettle, television and telephone. Staff made hourly well-being checks on new arrivals during the first 24 hours, but there were no subsequent follow-up welfare checks.

3.6 Induction started the following day, when a prisoner Insider gave a reasonably good introduction to life at the prison, although this took place on the landing as there was no dedicated induction space. Insiders showed new arrivals how to use the electronic kiosk to send applications and order items from the shop. However, arriving prisoners were not given any written information to help them understand what was on offer, and we spoke to some who were initially confused about what was available.

3.7 In our survey, only 49% of prisoners said induction covered everything that they needed to know, compared to 65% at the last inspection. Not all relevant departments attended induction sessions; for example the substance misuse team was not included. There was no published timetable and no management system in place to assure leaders that every prisoner had completed induction. Prisoners on induction spent long periods locked up with nothing to do during the week-long programme.

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

3.8 The level of violence had increased since the last inspection. In the 12 months before that inspection there had been 235 assaults, but for the equivalent period before this inspection the figure was 450. In our survey, 40% of respondents said they currently felt unsafe, against the comparator of 27% and 22% at the previous inspection.

3.9 Assaults against staff had been rising and comprised 58% of all assaults compared to 35% at the last full inspection. However, there had been a slight but steady reduction in assaults on prisoners over the previous 12 months and the rate of serious assaults was much lower than at the most violent category B training prisons. The rate of incidents and of concerted indiscipline had been reducing over much of the previous year.

3.10 The challenge, support and intervention plan (CSIP) system (see Glossary) was still not playing a significant role in work to address antisocial behaviour despite recent leadership focus and delivery of staff training. While more plans were being initiated, the safety team were constantly being redeployed which diverted them from conducting investigations, developing plans and upskilling colleagues.

3.11 The incentives system was operated in a traditional and limited way. There were hardly any pathways for progression to better facilities or privileges which might motivate prisoners to behave positively. One wing was being redesignated as an enhanced wing, but prisoners were dismissive of the very slight additional privileges that were being made available.

3.12 The weekly safety intervention meeting (SIM) was usually reasonably well attended by a range of professional disciplines including psychology and mental health. However, at the meeting during the inspection not all residential areas were represented, nor was the segregation unit. There was constructive discussion of some prisoners with complex risks and needs to help inform coordinated case management, but there was an inadequate focus on other groups, such as those who were self-isolating.

3.13 At both the last full inspection and the subsequent independent review of progress (IRP), prisoners who were self-isolating lacked access to an adequate regime and oversight by prison leaders. While the SIM now reviewed some self-isolating prisoners each week, there was no certainty that they were aware of everyone who was self-isolating, nor whether those prisoners were all given the necessary support or sufficient access to a regime. The safety policy placed responsibility on the under-resourced safety team (see paragraph 3.10).

Adjudications

3.14 The adjudications system remained largely in the same state of disarray that we noted at the last inspection. While the number of outstanding charges had been reduced from four figures to 430, this was still much too high and there were problems at every stage of the process, including issuing paperwork and bringing prisoners to the care and separation unit for their hearing. The independent adjudicator had withdrawn for a period because of the inefficiency of prison procedures, although this had recently been resolved.

3.15 Better leadership in the segregation unit was leading to early signs of improvement, for example by holding the governor who had opened an

adjudication hearing responsible for bringing it to completion. Much better liaison with the police and compliance with national policy were also reducing waiting times for serious cases referred to the police.

3.16 Oversight of the adjudication process was poor, and the usual standardisation meetings to regulate adjudication practice had not been taking place.

Use of force

3.17 Since the last full inspection in 2023, the use of force had trebled from 267 to 818 incidents, and only two similar prisons had higher rates. About two-thirds of incidents involved the use of full control and restraint, often to prevent harm to others or to ensure the return of non-compliant individuals to their cells.

3.18 In the previous 12 months, 65% of incidents had been captured on body-worn cameras (BWCs). However, in our review of footage, cameras were often not turned on early enough to capture the incident fully and not all staff were wearing them. We saw a few staff using good de-escalation, but in other cases the decision to use force was clearly taken too quickly and not as a last resort. Some prisoners told us of examples of excessive use of force, which they had complained about to prison staff. We found that these cases had not been fully investigated by the prison and, in one case of potentially excessive use of force, there was a concerningly poor use of BWCs where it appeared that a camera was deliberately turned away from an incident during which a prisoner was alleging excessive force and asking for the camera. This case was referred to leaders for further investigation.

3.19 During the previous year, batons had been drawn on 19 occasions and used on five, PAVA (incapacitant spray) had been drawn 32 times and used on 18 occasions, and a body belt had been used twice. Leaders told us they reviewed these incidents but could not show us any investigations or resulting actions.

3.20 Overall governance and scrutiny of force were weak. A monthly use of force meeting was poorly attended and had not always taken place, and there was no strategy to reduce the high number of incidents. A weekly scrutiny meeting did not review enough incidents or review them with enough rigour. For example, in one month, only three of 61 incidents had been reviewed using staff statements, but evidence from BWCs or CCTV was not viewed.

3.21 More than 140 use of force incident reports were outstanding, dating back over 12 months, and many staff statements that we viewed were not completed in enough detail to assure leaders that the force used was appropriate. A recently appointed use of force co-ordinator had started conducting debriefs with prisoners who had been restrained to learn lessons, but there was little outcome from this work so far.

3.22 Supervision of unfurnished accommodation was poor. Local data showed that it had been used four times in the previous 12 months, but

records to authorise justification were either missing or not fully completed.

Segregation

3.23 There was considerable use of the care and separation unit (CSU), with 288 episodes of segregation in the previous 12 months. Conditions in the unit were not good enough, with wear and tear, bad staining and some graffiti in cells, while showers were also in a poor condition. A programme of painting had started and communal areas had improved.

3.24 Most stays in the CSU were no longer excessive but, at the time of the inspection, two men with severe mental health conditions had been held for much too long in conditions of extreme custody (see paragraph 4.56).

3.25 New managers had been introduced to the unit and were having a positive impact: they were more visible on the unit and were bringing more structure and regularity to the regime. This had led to better multidisciplinary attendance at individual reviews, which were held three times a week with a clear focus on preparing for reintegration. The head of safety was leading these reviews wherever possible, with positive effects on the continuity and quality of monitoring and planning. A better approach to selecting and supporting CSU staff was starting to be taken and recent staff changes appeared to have led to an improving culture in the unit.

3.26 However, prisoners' access to a regime was still very limited, with no reliable daily access to showers, phone calls or adequate time in the open air. The reasons for this included frequent staff redeployment, a high occupancy rate and the presence of a number of high-risk prisoners requiring extra precautions before opening the cell door.

3.27 While individual managers were making a difference, there was no systematic governance and analysis of the use of segregation.

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.

3.28 Drugs were a very serious problem: the number of prisoners found to be under the influence of illicit substances had continued to rise in 2025, with 142 in January, 139 in February and March continuing in the same pattern. Drones were a particular concern and many drones were not intercepted. Renewal of netting was in progress over outside areas accessible to prisoners, and some other measures were in place or planned.

3.29 The random drug testing positive rate was high at 40.6% for the previous 10 months, and in our survey 56% of prisoners said it was easy to get hold of drugs, compared with 37% at the last full inspection. Our survey strongly suggested that vulnerable people were being exploited in this regard. Around a third of specific groups said they had developed a drug problem while at Lowdham Grange: 33% of those who had been in local authority care, 35% of those with a disability and 30% of those declaring mental health problems. Survey results for the general population were much lower at 13%, 6% and 2% respectively.

3.30 The security team had been strengthened with experienced managers brought in from other prisons, and there was now a team of six analysts where previously there had been one. A backlog remained of intelligence reports awaiting processing, although there were far fewer than at our previous two inspections. Effective daily triage was making sure that immediate actions were taken in response to fresh intelligence.

3.31 The dedicated search team had recently increased to 12 officers, who were not deployed to other duties, and this team was having an impact on improving detection and deterrence. Regular night-time searching and lockdown searches of specific areas had resulted in many finds over the last few months, especially of drugs and mobile phones.

3.32 Prevention and detection of staff corruption had improved, especially through much better collaboration with the police, which had resulted in arrests inside and outside the prison. Enhanced gate security was also a useful recent addition, but the very small space available created queues of staff outside the prison and an occasionally rushed searching process, reducing its effectiveness.

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

3.33 There had been 10 deaths since the last inspection, including two that were self-inflicted and four suspected of being attributed to drug misuse. There was a further death during the first week of the inspection. Leaders had not focused adequately on resolving the concerns identified in Prisons and Probation Ombudsman (PPO) reports or local learning reviews. Some PPO actions were outstanding from 2018, and reviews were not taking place often enough to make sure implementation remained effective (see paragraph 4.23).

3.34 Prisoners told us that significant triggers to self-harm were the inability to see any health professional, not only mental health staff, difficulties

in maintaining family ties and inconsistency with prison systems and regime. There had been 822 recorded self-harm incidents in the previous 12 months. Although the rate had been on a downward trajectory over the previous year, it was still the third highest among category B training prisons and 39% higher than at our last inspection.

3.35 While most incidents were not classed as serious, 46 had required hospital treatment over the last year, and one man had been placed in a body belt for his own safety. Investigations into serious self-harm were not routinely conducted, leaving leaders unaware of the underlying issues and limiting their ability to apply lessons learned to prevent future occurrences.

3.36 Constant supervision cells had been used 69 times in the previous year but there was no paperwork or evidence of reviews. The cells that we saw were in poor condition: some were dirty and most had no mattress. The safety team could not tell us how many times anti-ligature clothing had been used and there was no authorising paperwork. We could not be confident that either measure was being used appropriately.

Constant supervision cell (left) and toilet in constant supervision cell

3.37 At the time of our inspection, the ACCT process (assessment, care in custody and teamwork case management of prisoners at risk of suicide or self-harm) was supporting 36 prisoners, four of whom were in the segregation unit. In our survey, only 26% of prisoners on ACCTs said they had felt cared for and many care plans that we saw were poor, with very few identified activities to help prisoners. Only 19 of the 36 prisoners on ACCTs were taking part regularly in education, training or work. Leaders had provided more training for ACCT case managers and had recently reorganised the review process to ensure more consistent case management.

3.38 The prison did not keep records of all self-harm that had taken place in the segregation unit, a known high-risk area in all prisons because of the limited time out of cell and less interaction with staff and other prisoners. This was particularly concerning in light of a self-inflicted death in segregation in 2023.

3.39 Data were not used well at monthly safety meetings which were not sufficiently multidisciplinary and did not generate appropriate actions to drive progress in reducing self-harm. Leaders attributed much of the self-harm to debt, regime issues and lack of mental health support, but neither the data nor prisoner consultation to support this assertion were robust. A safety analyst was due to start in the near future and managers had recently created a self-harm trigger database.

3.40 The Listener scheme had been introduced about six months before the inspection and 11 trained Listeners (prisoners trained by the Samaritans to provide emotional support to fellow prisoners) were regularly supported by the Samaritans. However, use of the scheme was low and, in our survey, only 16% said it was easy to see a Listener compared to 41% in similar prisons. Local data showed that in the month before the inspection, staff had offered Listener support 21 times, but they had only been called on eight occasions. The reasons for this had not been explored.

Protection of adults at risk (see Glossary)

3.41 There was no local safeguarding policy and no links with the local safeguarding adults board. At the time of inspection, five safeguarding concerns were being managed through the weekly SIM, but it was unclear what actions were being taken to support prisoners. Only 10 staff had been trained in adult safeguarding and most did not know how to identify a safeguarding issue or how to make a referral.

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, only 54% of prisoners said that staff treated them with respect against 70% in similar prisons. Some prisoners reported rude and dismissive behaviour by staff and many said they could not get issues resolved because of staff inexperience or poor systems. While we also saw some good interactions, morale was low, staff were often very busy and some seemed to be disengaged.

4.2 Many staff had experienced considerable change and uncertainty over recent years, and they lacked adequate support from visible middle managers. More positively, there were advanced plans to provide a dedicated team of staff mentors.

4.3 Key working (see Glossary) was not operating effectively: fewer than 20% of planned sessions had been delivered in the previous six months and sessions did not focus adequately on progression or risk. We found one prisoner who had not had a key worker session since 2023, and some staff were delivering sessions via in-cell telephones rather than in person. Leaders had recently prioritised key work sessions for the most vulnerable prisoners, and this had been working well so far.

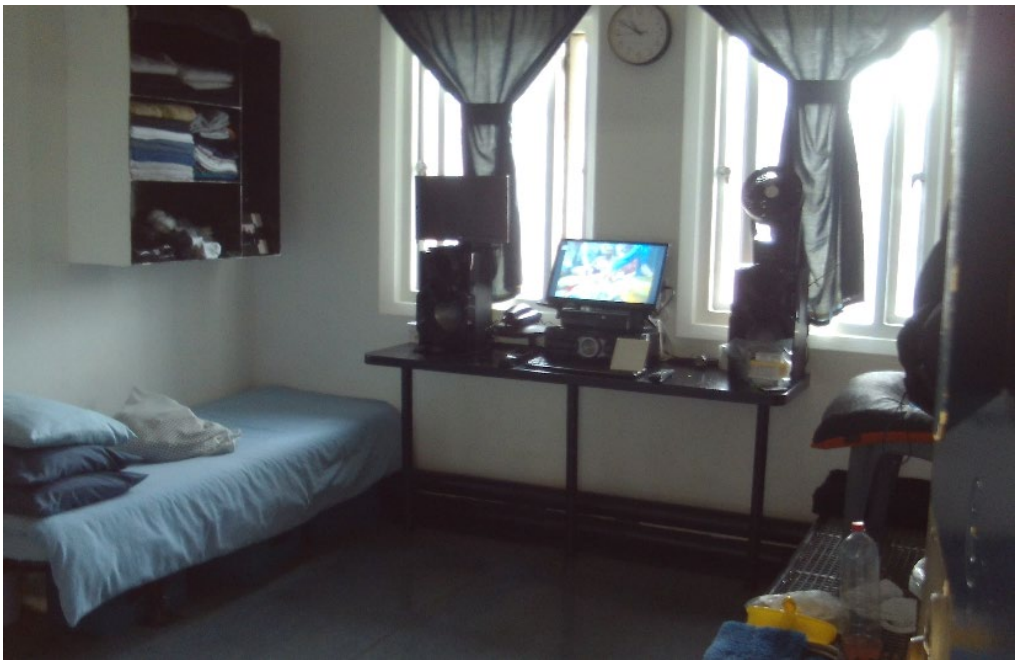
4.4 Peer working was underused. There were some Listeners, equality representatives, Insiders and PAL (prison advice line) workers, which were all valuable roles. However, many peer workers had been left without support or direction from staff and, as a result, were not being used to their full potential (see paragraph 3.40).

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

4.5 All prisoners lived in single cells and the prison was not overcrowded. Cells were generally well maintained by prisoners who valued the opportunity to personalise their space during often long sentences.



Induction unit cell

4.6 Internal communal areas were tidy but were not always clean. There was insufficient oversight and stock control of wing cleaning materials by staff. Wing cleaners reported that they frequently had no equipment and, in our survey, only 44% of prisoners said they could get cell cleaning materials every week, lower than at similar prisons. We saw many poorly stocked cleaning cupboards and as a result prisoners were improvising by, for example, using toilet roll to clean microwaves.

4.7 The prison grounds were pleasant and well maintained, but exercise yards were small and often heavily littered with rubbish thrown from cells. Wings had minimal association equipment, including pool tables and some gym equipment, but it was not all in working order.

Prison grounds (left) and litter on exercise yard

4.8 Three of the houseblocks had in-cell showers, which prisoners appreciated. However, the shower facilities on the larger units lacked privacy, were not well cleaned and there was inconsistent access. In our survey, only 69% of prisoners on houseblocks one and two said they could get a daily shower and only 40% said the showers were clean.

Houseblock one and two showers

4.9 Cell bells were not answered quickly enough. Prison data showed regular waits of over 20 minutes and, in our survey, only 12% of prisoners said their cell bell was answered within five minutes, compared to 36% at the last inspection. Scrutiny of cell bell data was not used to drive improvements, and managers and staff were not held to account for unacceptable delays.

4.10 Wing laundries were working well but there were no stores of prison issue clothing or bedding on wings, and processes to obtain basic items were too bureaucratic. One prisoner had, for example, waited two weeks to be issued with a towel and, in our survey, only 30% of prisoners, compared to 65% at the last inspection, said they could get clean bedding every week.

4.11 In the previous 12 months, 23% of complaints related to property, especially poor management of property during cell clearance and wing moves. Leaders told us that, in some cases, staff were unwittingly allowing prisoners access to other prisoners' cells and were reviewing processes to identify and resolve issues.

Residential services

4.12 In our survey, 31% of prisoners said the food was good, similar to other prisons. Hot food was served at both lunch and dinner, but meals were sometimes served well before the advertised times of 11.45am and 4.30pm. Muslim prisoners observing Ramadan were not always given food that they could store adequately in the thermos flasks provided to them, resulting in cold or soggy meals (see paragraph 4.27). All wings had communal dining areas, but self-cook facilities were poor, which was a significant omission for a long-term population.

Communal dining area on wing (left) and self-cook facilities

4.13 The canteen was based on site, which meant that new arrivals received their first orders quickly and missing items could more easily be replaced. Prisoners were able to buy fresh fruit and vegetables, cheese and butter each week, which was positive. However, the online ordering system often incorrectly reported items as out of stock and, in our survey, only 24% of prisoners said the canteen sold what they needed compared to 49% at similar prisons.

4.14 These problems were compounded by the fact that catalogue orders had been suspended from September 2024 to January 2025 because of persistent logistical problems following an ineffective transfer of finance responsibilities from Sodexo to HMPPS. A large backlog of

order requests was awaiting approval, some of which were more than a month old, and prisoners no longer had access to clothing parcels.

Prisoner consultation, applications and redress

4.15 Leaders had not done enough to develop and maintain avenues to seek prisoner views in recent months. There were pockets of consultation focused on specific areas, but the Prison Council was no longer in place, and only 31% of prisoners in our survey compared to 52% at similar prisons said they were consulted about matters like food, canteen or wing issues. A new Prison Council was being established.

4.16 Responses to complaints and attempts to resolve prisoner issues were poor, and heads of function had not taken sufficient ownership of delivery within their areas of responsibility. In our survey, only 9% of prisoners who reported having made a complaint said it was dealt with within seven days and prison data showed that around 40% of responses fell outside target response times.

4.17 Complaint responses showed little evidence of investigation. In our survey, only 13% of prisoners who had made a complaint said it was usually dealt with fairly and more than half of those with a disability (59%) and with mental health problems (56%) said they had been prevented from making a complaint. New assurance mechanisms were being set up during the week of the inspection.

4.18 The paper application system was very badly administered; there were over 1,500 pending paper applications at the time of the inspection, 738 of which were from 2024. Many prisoners used the electronic messaging system available on kiosks and via in-cell technology. Although it was a good tool, many messages received no response and there was no monitoring of timeliness or quality of responses. Data on delays by department were not used to challenge functions or improve outcomes.

4.19 Legal visits ran each morning during the week and legal texts were readily available. However, there were not enough video link slots for court, legal and probation bookings and staff told us that both solicitors and prison offender managers (POMs) found it challenging to secure slots. In one case, a POM had to wait a month to facilitate a pre-release meeting. In our survey, only 33% said it was easy to communicate with their solicitor or legal representative and 26% said it was easy to attend legal visits, both lower than at our last inspection.

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.

4.20 Work to promote fair treatment and inclusion was poor. There was no strategy and no meetings or forums with prisoners. Data were not being analysed to understand and respond to the needs of the population. There were 11 equality and diversity representatives, but they were not supported or used effectively. A manager was being recruited to take responsibility for this area.

4.21 Discrimination incident report forms (DIRFs) were not always available on the wings and there were still no clearly identifiable boxes for submitting them. Leaders were unable to provide a full log of DIRFs they had received and, of the 71 they were able to account for in the previous year, only 10 prisoners had received a response. Unsurprisingly, prisoners told us they had no faith in this system.

4.22 Prisoners with neurodiverse needs and those aged 25 and under were now being identified in safety meetings, and some early work was being done to look at the needs of these groups. Veterans continued to be offered helpful support from the Veteran Care Through Custody programme, funded by the NHS. They were allocated one-to-one time with a mentor and monthly meetings, which was appreciated by the prisoners we spoke to.

4.23 Foreign national prisoners, who made up 12% of the population, no longer had a dedicated member of staff supporting them. Only a few prisoners had a foreign national phone PIN to make cheaper international calls because there was no longer anyone to organise provision since the loss of a dedicated foreign national officer. Video visits were not available outside the core day to provide flexibility to call family and friends abroad. There were no ESOL (English for speakers of other languages) courses available and, instead, the Shannon Trust (charity that supports people in prison to learn to read) mentors supported some of this group (see paragraph 5.25). Despite a PPO recommendation to this effect, staff were still not using interpreting when required and leaders were unable to provide any evidence of the use of professional interpretation services.

4.24 We found prisoners with disabilities living in neglectful conditions, some having made their own cell adaptations. There were no trained buddies in the prison and there were no plans in place for men who required social care support. Not all prisoners who required a personal

emergency evacuation plan had one and most staff were unaware of them.

4.25 Little was being done to identify and respond to the needs of other groups. For example, other than a dedicated gym slot, there was no provision for those aged over 50.

Faith and religion

4.26 Despite a new full-time member of the chaplaincy starting during the inspection, there were still gaps in the service. Only half the prisoners in our survey said they were able to speak to a member of the chaplaincy in private if they wanted to and the team was not visible around the prison.

4.27 Many Muslim prisoners were unable to attend Friday prayers, which operated a waiting list because of a lack of space. There were too few chaplaincy hours to meet the needs of Muslim prisoners, who comprised nearly a third of the population. Regime curtailments had affected several services over the last few months. Arrangements for Ramadan meals were poor (see paragraph 4.12) and plans for Eid had yet to be finalised.

4.28 The chaplaincy prioritised seeing prisoners in the segregation unit each day and attended ACCT reviews when requested. A Living with Loss programme had recently started for prisoners who wanted support following bereavement, and there had been 12 completions to date. There were no other groups or forums outside corporate worship. Plans were being drawn up to provide official prison visitors through the chaplaincy.

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.

4.29 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 took enforcement action in the form of a notice of proposal under Section 12 (5)(a) of the Health and Social Care Act 2008. The regulatory breaches will be followed up with the health care provider.

Strategy, clinical governance and partnerships

4.30 Health services were poor. They did not meet the needs of patients and in some cases were unsafe. Fragile leadership, significant clinical vacancies, high sickness absence, weak governance and the very high number of emergencies caused by illicit drug use had led to an

overstretched service and very poor patient outcomes across most pathways.

4.31 Despite meeting monthly, the local health care delivery board was ineffective, with multiple actions failing to be addressed. Partnerships within the prison were weak and not sufficiently patient focused. NHS England held quarterly contract meetings with the provider and bi-monthly performance information meetings focused on improving the provider's data reporting. Health services were no longer providing round-the-clock cover, which was very problematic given the complexities of the population and high prevalence of illicit drugs. The health needs analysis completed in 2022 had not been reviewed.

4.32 Clinical governance and oversight of the service were failing to support service delivery or improvement. There was no clinical audit and limited evidence of clinical governance meetings. The current head of health care was the fifth in two years and was in an interim capacity. Compliance with mandatory training by clinical staff was low. Many appraisals were outstanding and supervision arrangements were ineffectual.

4.33 Long-standing vacancies permeated across most pathways and stood at 45%, with agency and bank staff providing some cover. This was compounded by a high sickness absence rate. Resources were further stretched by high did-not-attend (DNA) and no-access-visit (NAV) rates: only 75% of health clinic appointments had been used over the previous three months.

4.34 Ulysses (an incident reporting system) was used to record clinical incidents. Although the number of incidents reported was high, some staff told us that they felt leaders discouraged them from reporting. Reported incidents were reviewed, but learning was not effective. It was especially concerning that investigations into three recent deaths in custody had each identified failure to follow up non-attenders. We found a significant number of patients with gaps in care that were raised with Nottinghamshire NHS Foundation Trust (NHFT).

4.35 Patient feedback systems were far too limited and many prisoners complained to inspectors about poor health care. A confidential complaints system was in place, but complaint forms were not always available on the wings and there was a significant backlog of complaints awaiting a response: one patient had waited over 300 days for a response to a complaint which was still outstanding during the inspection.

4.36 Emergency life support kit was strategically placed across the prison, contained the necessary items and was subject to regular checks. We were advised by the prison that an ambulance was always called in an emergency and there were no delays in them entering or exiting the prison. As health services were not round the clock, it was positive that prison officers had access to nasal Naloxone (a medicine used to treat opiate overdose).

Promoting health and well-being

4.37 There was no overarching health promotion strategy to guide joint work between health care and the prison. Health promotion leaflets and information about health services were available, but in English only. The local in-prison television service had been used well to promote TB screening and provide help and guidance to patients. There were no trained peer health champions.

4.38 A range of age-appropriate health screens and vaccinations was offered routinely, including sexual health support and access to barrier protection. Patients had good access to visiting specialist sexual health services.

4.39 There were systems to deal with communicable disease outbreaks, with good partnerships established with Public Health England, which had been tested following a need for mass TB screening. This was continuing and there was good oversight of patients who were still to be screened.

Primary care and inpatient services

4.40 There was a seven-day nursing service between 7am and 7.15pm, led by an interim primary care matron and supported by a clinical lead, and staff told us that they felt supported by managers. The permanent GP worked one day a week and the provision was supported by locum GPs and an out-of-hours service. Staff shortages and the unrelenting demand to review patients under the influence of illicit substances affected all aspects of primary care service delivery.

4.41 Health care applications were submitted electronically and triaged by a nurse. However, the application was not then routinely recorded and information sent by the patient was not available to clinicians. In our survey, 75% of respondents said it was difficult to see a doctor. The GP waiting list at the time of the inspection contained 117 patients with the longest wait being 13 weeks.

4.42 The clinical rooms did not meet infection prevention standards. The waiting rooms were bleak and small for the number of patients held.

4.43 Initial reception health screenings took place, but the second physical health screen was not always completed promptly, posing a potential risk to patient health and well-being. A nurse with specialist training reviewed all patients with a long-term condition, who were well managed and had annual reviews.

4.44 Staff shared important information about patients at daily handover meetings and multidisciplinary meetings were held weekly to discuss those with complex needs. However, clinical records were inadequate and posed a significant risk to patient safety. We could not be confident that they provided a continuous narrative of the patient experience.

4.45 The governance of external hospital appointments was poor. There was no effective oversight, which meant that referrals, outpatient

appointments and clinic letters were not monitored or followed up, posing a risk to ongoing care and patient safety. Some routine appointments had been cancelled and we found examples of unacceptable delays to urgent A&E assessments and a two-week wait for appointments.

4.46 A range of allied health professionals visited the prison and waiting times were reasonable, with an average wait of around eight weeks.

4.47 All patients leaving the prison were seen by a nurse and, if due for release, were given any medication they required and a GP summary.

Social care

4.48 No prisoners were in receipt of a social care package (see Glossary) at the time of our inspection, although several prisoners had received aids and adaptations to help them maintain their independence. A memorandum of understanding (MOU) between the prison, the local authority (NCC) and the health and social care provider (NHFT) set out clear arrangements for accessing social care.

4.49 Prison and health care staff were active in identifying prisoners with potential care needs and making appropriate adjustments or onward referrals. Assessments were timely and a community agency provided care where required. There was no formal buddy system (prisoner support workers to help prisoners with low-level social care needs). There were effective referral and assessment pathways, but the oversight of referrals was through a database accessible by only one member of health care staff.

Mental health

4.50 The mental health team was failing to meet the high level of need in the prison. Only 15% of respondents in our survey said it was easy to see a mental health worker and we found that patients faced unacceptable delays in getting care and treatment from the team. The mental health of some prisoners had deteriorated as a result and, concerningly, there was no clinical oversight of those on the waiting list, which increased risks significantly.

4.51 A total of 163 prisoners were waiting for an assessment and a further 63 were waiting to start treatment. The longest wait was one year eight months. Psychiatric provision was inadequate with 17 patients waiting to be seen by a psychiatrist, some since November 2024.

4.52 Despite having a neurodiversity (ND) pathway which could offer assessment and diagnosis, a vacant practitioner post had prevented the service from taking referrals since December 2024. Forty-two prisoners were waiting for an assessment and those already on the ND caseload received only minimal support from a visiting practitioner. NHS Talking Therapies was being delivered alongside psychological treatment, but patients faced long waits for an assessment (18 weeks) and to start therapy (25 weeks).

4.53 Leadership was lacking: an interim clinical lead supported the team two days a week but had only been in place for four weeks. The team met weekly to discuss referrals and allocations, but minutes were not taken of these meetings and the provider was unable to demonstrate that annual physical health reviews for those with severe mental illness or learning disabilities were being carried out.

4.54 The assistant practitioner continued to facilitate sessions for patients in the well-being centre but cross-deployment of safer custody officers and of the practitioner caused the regular cancellation of sessions. Patients we spoke to valued these sessions when they took place. The sensory room could not be used as staff were not trained in its use.

4.55 Patients generally did not have an up-to-date care plan and care plans for the few that did were not personalised or reviewed. This carried considerable clinical risk due to the high numbers of agency staff being used to backfill vacancies. Significant gaps in some records made it difficult to understand patient care.

4.56 During the previous 12 months, five patients had been transferred to hospital under the Mental Health Act, none of whom was transferred within 28 days and the longest taking 184 days, which was unacceptable. Two extremely unwell patients, who had waited for 152 and 99 days, continued to be housed in segregation with a very basic regime.

4.57 The mental health team's attendance at ACCT reviews had recently improved and a mental health nurse attended segregation each day.

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

4.58 An integrated substance misuse team supported approximately 170 patients. The team had high vacancies and sickness, and clinical team members were frequently required to administer medicines.

4.59 The regional manager attended the prison drug strategy meeting where possible. There had been a recent meeting between the prison, health provider and NHSE commissioners to discuss a joint approach to managing the very high number of patients under the influence of illicit substances.

4.60 The team worked very hard to see all patients reported to be under the influence of illicit substances and offer harm minimisation advice. This, alongside the staffing challenges, had led to a backlog of assessments and at the time of inspection 42 patients had been waiting up to 17 weeks to receive an assessment.

4.61 Patients could self-refer to the service and all new arrivals were screened for any substance misuse concerns. Where appropriate, their care was reviewed by a prescriber to continue opiate substitution therapy (OST).

4.62 Clinical treatment of opiate addictions was evidence based, with approximately 170 patients in receipt of OST. Treatment was overseen by an experienced non-medical prescriber who visited the prison twice a week to manage the clinical caseload. Prescribing was flexible and patients could receive oral or injectable Buprenorphine if requested; OST was administered alongside routine medicines on houseblocks 1 and 2. Patients in receipt of OST received routine 13-week reviews to monitor their treatment, and, when possible, recovery workers attended these reviews to develop joint care plans.

4.63 The provider worked to a four-tier model to deliver psychosocial interventions to patients. Tier 1 and 2 interventions were delivered through one-to-one activity and a very limited number of groups that had recently restarted after a considerable gap. At the time of inspection there were no tier 3 or 4 treatment options for patients, which was poor.

4.64 There was no incentivised substance-free living wing in the prison and mutual aid support was limited to Alcoholics Anonymous, who attended the prison each week.

4.65 The substance misuse team referred all patients on their caseload to community substance misuse services and all patients were offered Naloxone to take home.

Medicines optimisation and pharmacy services

4.66 Medicines were dispensed by an external pharmacy, which was a different organisation to the on-site health care provider. The pharmacy delivered its services in a safe and timely fashion. Several patient group directions (which allow registered staff to administer some medicines without a prescription) and a well-defined homely remedy policy enabled the health care team to supply a wider range of medicines.

4.67 Queues at medicine hatches were sometimes disorderly and officer supervision was inconsistent. Some of the hatches did not provide a confidential space. There were systems to record, identify and refer patients who did not attend to collect their medicines. Patients who were being transferred or released were provided with a minimum of seven-days' supply to ensure continuity of medication.

4.68 Most (83%) of the population were able to receive their medicines in possession, usually with a 28-day supply. Prescribing and administration were both completed on SystmOne (electronic clinical records) and in-possession risk assessments and medicine reconciliation were completed within designated timescales on reception. However, assessments were not always reviewed annually to make sure they remained relevant. An in-possession risk assessment clinic led by a pharmacy technician was used to improve this work.

4.69 A multidisciplinary safer prescribing forum routinely reviewed and optimised patients' use of tradeable medicines. However, there was no regular pharmacist provision and medication reviews were not available.

4.70 The pharmacy team was well integrated with the rest of the health care department. There were daily multidisciplinary staff meetings to discuss prisoners' care, but local drug and therapeutic meetings had not taken place for some time.

Dental services and oral health

4.71 Dental services were well led. Experienced and motivated staff delivered good quality care to patients. Additional clinics had considerably reduced the waiting lists which had more than halved. Waiting times for first appointments and routine care averaged eight weeks and the team proactively managed the small number that were waiting for more than that time.

4.72 All applications for an appointment were appropriately triaged and prioritised. A full range of NHS-equivalent dental services were available to patients. Clinical records we looked at demonstrated a comprehensive oral health assessment for all patients. Patients with urgent dental care needs such as those in pain were able to access emergency appointments when the dentist was next in. Patients requiring external dental treatment were referred in good time but one patient who had been referred under the two week-wait guidance had not gone out and his appointment had been subject to delay, which was unacceptable.

4.73 The dental suite was clean and systems were in place to ensure the safe decontamination of equipment. All equipment was safe to use and well maintained. Although the room was small, there was sufficient space for wheelchair users to transfer into the dental chair which was appropriate and provided equality of access.

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 The regime was inconsistent and regularly curtailed, which was one of the biggest frustrations for prisoners. Staff often started work late in the morning because of problems getting into the prison (see paragraph 3.32). This led to prisoners being unlocked late and hindered their ability to complete domestic tasks, take exercise and attend education and work on time. There were some on-wing activities, mainly consisting of a pool table and some exercise equipment, although most of the equipment was not working. Limited exercise equipment was available in the yards.

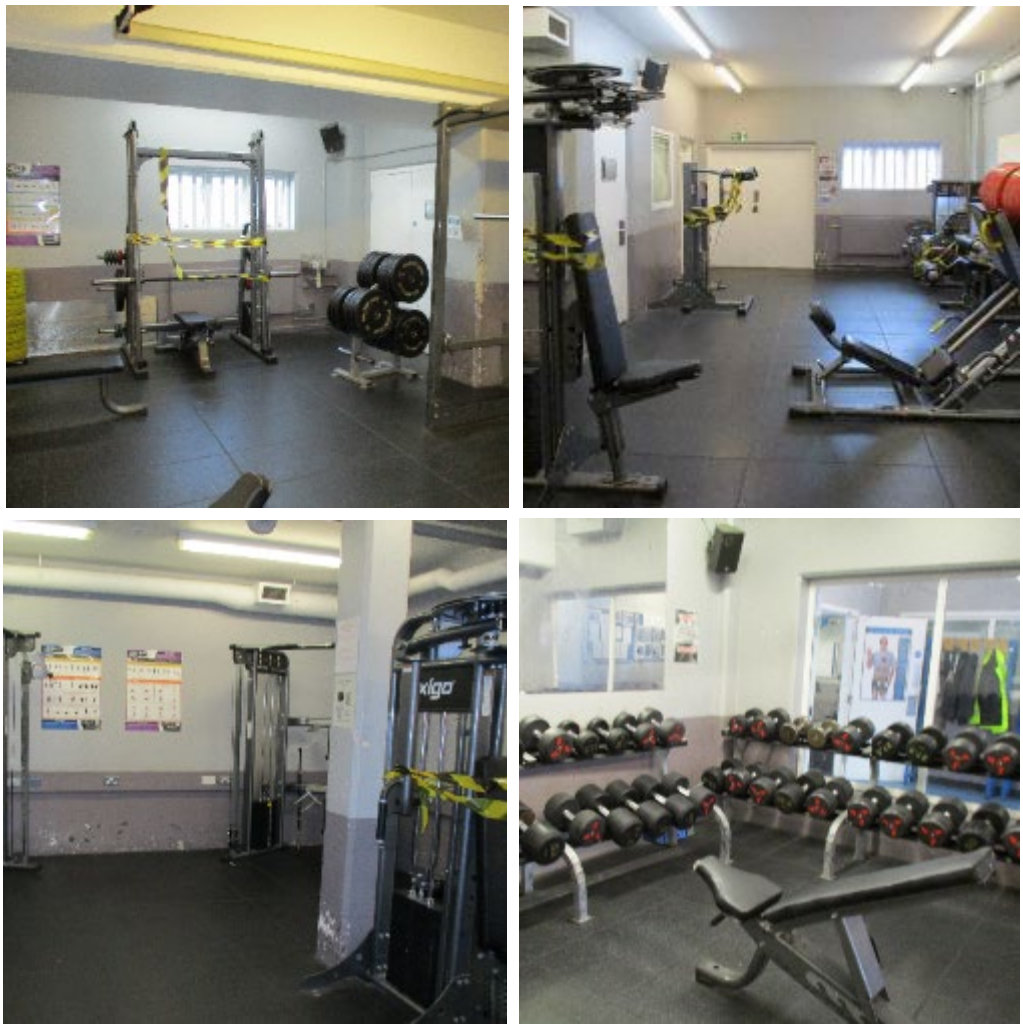
5.2 Our roll checks found 43% of prisoners locked in their cell during the working day and only 34% off wings in purposeful activity. Staff were not always sure of the roll on their wings, which was concerning. The regime allowed for up to eight hours a day out of cell for those who were on enhanced level and working, and as little as two hours 45 minutes for those on basic regime. This was further reduced at weekends and there was no opportunity for evening association. We found retired prisoners locked in their cell during the day and there was no separate regime for prisoners who were self-isolating (see paragraph 3.13). A planned weekly lockdown day for staff training was due to limit time out of cell further.

5.3 Most prisoners attended the gym once a week, including those on enhanced regime, who were supposed to have gym access three times a week. There was a good size team of PE staff but they were often cross-deployed and gym sessions were sometimes cancelled as a result; half of the weekend football matches for prisoners had been cancelled in the previous five months.

5.4 A popular twinning project with Mansfield Town Football Club had started in the last year; it engaged prisoners in a programme to help improve physical and mental well-being and led to a qualification. However, it was the only course or qualification being delivered, partly because staff were not yet suitably qualified themselves. There were plans to have all staff trained in the coming months.

5.5 The sports field was in good condition, but the indoor gym equipment had been in a poor state for some time, leading to potentially serious

health and safety concerns. We were told that replacements had been ordered and would arrive imminently. There was no shower or changing area for prisoners and, dependent on their unit and regime, some were unable to shower when they were back on the wing.



Gym area with some broken equipment (top left and right), gym area with some broken equipment and some damage to the walls (bottom left) and weights area with some weights in poor condition (bottom right)

5.6 The library, delivered by Novus, was underused and only open during the week with no evening or weekend access. Although a limited number of books were available in the workshops and segregation unit, there were no libraries on the wings or any active promotion of the facilities available. There had been a recent visit from an author to speak to prisoners, but few other initiatives to promote reading.

5.7 Library data were not being monitored or analysed to help develop services. There were not enough materials to meet the needs of the population. There were no links with local libraries in the community and some of the materials were quite dated. Provision for foreign national prisoners was limited and some key legal texts were not available.

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.

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

Overall effectiveness: requires improvement

Quality of education: requires improvement

Behaviour and attitudes: requires improvement

Personal development: requires improvement

Leadership and management: requires improvement

5.9 Senior leaders were working towards implementing their ambitious vision to provide appropriate employment, education and other meaningful activities for all prisoners. Since the previous inspection, senior leaders had broadened the curriculum to better meet the needs of the prisoners. They had introduced courses from pre-entry to level 2 and a wider range of vocational options, with appropriate accreditation. More prisoners benefited from studying appropriate, valuable courses. However, due to a staff vacancy, leaders did not provide a suitable curriculum for the small proportion of prisoners for whom English was not their first language.

5.10 Working closely with the education sub-contractor Novus, managers had improved the quality of education. They had successfully responded to two of the three concerns identified at the previous full inspection, although the concern regarding the number of activity spaces still remained.

5.11 In line with the needs of prisoners, they had introduced a course to support weaker readers and extended the range of English and

mathematics courses. They had introduced courses and qualifications in warehousing, horticulture and waste re-cycling. Leaders had developed a media course, which enabled prisoners to develop high-level digital skills and to work with industry-standard software, in line with the latest labour market requirements. Teachers were highly skilled and inspired prisoners to develop skills in animation, video development and script writing. As a result, some prisoners had been supported to send animated messages home and one prisoner developed inspirational teaching resources for local schools on the impact of crime.

5.12 Leaders did not provide sufficient activity places for all prisoners and too many prisoners were unemployed. Leaders' plans to increase activity places were well advanced but not yet implemented. For example, leaders had already invested in a new workshop to assemble bicycles with an innovative bamboo structure and had established a salon for barbering. Its popularity with prisoners had meant that many had enrolled already to do this course. However, it was too soon to judge its quality.

5.13 Leaders had improved the induction process and it was effective. Following the appointment of a specialist careers, information, advice and guidance (CIAG) adviser, prisoners understood their options in the prison and how they fitted into their long-term plans. Working with the CIAG adviser, prisoners created meaningful personal development plans which helped to sequence the activities that prisoners undertook.

5.14 Leaders had improved the process for allocations. Staff met weekly and discussed allocations across the whole of education, skills and work, including wing work. As a result, staff allocated courses with consistency and fairness. In recent months, they used the personal development plans as the key document for making allocation decisions. However, too many prisoners had to wait a long time to get onto courses. Some prisoners were waiting for security risk assessments to allow them to work in specific settings. Others were waiting for spaces in English and mathematics classes to become available. Although staff were successfully reducing waiting lists over time, prisoners became frustrated by the waiting times.

5.15 Leaders had produced a pay policy which gave equal monetary reward for education, skills and work and was not a disincentive to attending education.

5.16 Leaders and managers provided good oversight of the quality of education. They used data systematically to identify causes for concern. They reported consistently against key quantitative indicators, such as attendance and withdrawals. Leaders used visits to lessons and well-structured professional discussions to gain an accurate understanding of the strengths and weaknesses. Leaders had used performance management processes well to support teachers and instructors. Leaders' actions had contributed to recent improvements in the quality of teaching in mathematics and waste management, and attendance in industries.

5.17 Teaching staff were appropriately qualified and had received recent training to improve teaching. Instructors had achieved or were working towards appropriate teaching qualifications. They had extensive industrial experience and knew the subject content appropriate to their workshop. As a result, they taught the prisoners relevant subject-specific technical language and skills.

5.18 Novus provided the education and vocational training in the prison. Teachers used prisoners' starting points well, to shape what and how they taught them. Most teaching in education was strong. Teachers ordered the curriculum so that prisoners improved their understanding over time. Teachers gave clear explanations and provided expert practical demonstrations which helped prisoners to gain practical skills. Most teachers provided enough opportunities for prisoners to return to topics and practise what they had been taught. As a result, prisoners were able to explain and demonstrate what they had learned. Most prisoners had received external validation of the quality of their work through examinations. However, too few prisoners achieved their qualifications in mathematics.

5.19 Staff identified and provided detailed support plans for prisoners with additional learning needs. Teachers in education used these plans effectively within their lessons and prisoners with additional learning needs made progress and achieved qualifications in line with their peers.

5.20 Teaching in media, English and art was strong. In media, teachers skilfully crafted the curriculum so that it included the skills that prisoners would need if they moved into employment, self-employment or wanted to contribute to prison life. One prisoner developed teaching resources for local schools about the effects of crime on individuals, families and society. In English, teachers clearly explained the use of headings and paragraphs in text and then supported prisoners effectively in the production of their own text. They also improved prisoners' reading skills through regular sessions, which included reading aloud and effective techniques for reading to find information. In art, prisoners explained how their artwork was based on the drawing skills they had learned at the beginning of the course and the influence of historical art movements.

5.21 Within work and workshops, prisoners developed an appropriate range of basic and higher-level skills. Instructors supported prisoners to develop the new knowledge and skills they needed for employment. In most cases, staff matched prisoners well to the role they were undertaking. Most prisoners developed a wider understanding of their roles in the process, the technical language, and the personal and team skills required at work. Some prisoners gained responsibility within the workshop to supervise and manage prisoners and quality processes. Prisoners understood the demands of working to meet the requirements of a business contract.

5.22 Within the kitchens, staff rotated prisoners around the different workstations. Prisoners developed a wide range of appropriate culinary

skills. In the bistro, prisoners prepared all the food from the basic ingredients and demonstrated professionalism and teamwork. In horticulture each prisoner was able to describe how they had planted seeds and had considered the light, heat and watering to meet the individual needs of each plant.

5.23 Staff did not provide prisoners, working as cleaners and servery workers on the wings, with sufficient training and oversight, and therefore these prisoners did not improve their skill levels sufficiently over time.

5.24 Leaders had appropriate policies and risk assessments for each of the workshops and work areas.

5.25 Leaders had developed a well-considered and comprehensive reading strategy. They had made a positive start in implementing the strategy within education. Leaders had rightly prioritised support for the weakest readers. They had selected and used an appropriate initial assessment to identify them. Leaders had recruited a specialist teacher to support these readers and to work closely with the Shannon Trust. Leaders had started a class in education to support non-readers. Using high-quality phonics-based learning resources, the teacher provided effective support, and the prisoners made progress. In the wider education curriculum, teachers encouraged prisoners to read. In art, teachers loaned textbooks for prisoners to take back to their cell so that they could learn more about the subject. Teachers developed the artistic vocabulary of prisoners by introducing principles, such as rhythm and proportion. However, leaders had not extended the development of reading into work, workshops and on the wings.

5.26 Too few prisoners attended courses in mathematics and English. Attendance was higher in personal development courses, art and media. It was high in vocational training and industry workshops. Due to the regime, prisoners frequently arrived late for purposeful activities.

5.27 Most educational and work environments were calm and respectful. Prisoners said they felt safe while working across education, skills and work. Staff set clear expectations for prisoner behaviour. In education, most prisoners focused on learning and were appreciative and positive about the support they received from teachers. Most prisoners listened to and showed respect to teachers and other prisoners. On the few occasions that prisoners used inappropriate language, staff intervened quickly and prisoners improved their behaviour.

5.28 In work, prisoners showed the behaviours required by employers. In the kitchens and upholstery workshops, instructors established professional and productive work environments that mirrored the standards of external work, and motivated prisoners. Prisoners took pride in their work.

5.29 Most prisoners could explain the meanings or importance of equality and diversity and demonstrated respect to staff and fellow prisoners. For example, prisoners could explain the importance of International

Women's Day. Prisoners learned about the impact of Fairtrade around the world through a reading exercise in English.

5.30 Leaders had designed a personal development curriculum which included courses on how to change behaviours. Prisoners described how it improved their understanding of conflict resolution and the consequences of their actions.

5.31 Teachers and instructors used mentors effectively within education and work. Mentors encouraged more anxious prisoners to stay in the session and provided individual support when the teachers and instructors were involved with the larger group. This contributed to the progress individual prisoners made and the positive and purposeful working environment. Mentors described how these roles improved their own confidence and self-esteem.

5.32 The prison population comprised prisoners with long sentences, who stayed at the prison for more than two years on average. Most prisoners were transferred to other prisons, although a small proportion were released into the community. For these prisoners, leaders did not provide sufficient timely and detailed guidance on careers or money management. Prisoners did not make extensive use of the virtual campus, the computer-based careers resource. Leaders did not prepare these prisoners well enough for release.

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 Work to support family ties was underdeveloped. The part-time family worker had done some good work but could not reach enough prisoners. A new provider was due to start soon and we were told that new provision would include support for visitors and play activities for children.

6.2 The six weekly visit slots did not provide enough space for every prisoner to have one visit a month and the inadequate visits booking system further limited provision. Some prisoners had not been able to see their family or friends for months as a result. Visit spaces were released once a month at midnight and prisoners with an in-cell laptop could book their monthly allowance at this time. Other prisoners had to wait until the following day for access to the kiosk and usually found the spaces had gone, causing a great deal of frustration. We were concerned to hear reports of some prisoners block-booking visit spaces and then selling them to others, creating an illicit market. Ironically, visits sessions were still often half full because prisoners had not used, or potentially sold, the slots they had block-booked.

6.3 We found that 152 prisoners had never had a visit. The prison had not identified them or offered support. There was no prison visitors' scheme but the chaplaincy was developing a scheme (see paragraph 4.28).

6.4 Twelve family days were being delivered throughout the year and they were run well. Each of them had a theme which was mainly focused on the children in attendance. Prisoners were required not to be on basic regime or have any adjudications in the previous three months. Photographs were now available on all visits, including family days, but cost £5 for two.

6.5 The visits hall and food were basic. Toys were mainly aimed at younger children and were not all in good condition. It was positive that new furnishings had been ordered to start a necessary refurbishment.

Visits Hall

6.6 No family interventions were being delivered at the time of the inspection. The successful Storytime video service that we found during the last inspection had only just restarted after a gap of some months.

6.7 There were plenty of video visit spaces through the week, but these were only half full and there was not enough promotion of this service. The email-a-prisoner scheme was well used, but the prison did not offer a voicemail service.

Reducing reoffending

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

6.8 The prison was not achieving its purpose as a category B training prison and many of the prisoners we spoke to said they felt stuck at Lowdham Grange and frustrated by their lack of progression. In our survey, only 39% of prisoners said their experience was less likely to make them re-offend in the future compared to 57% at the last inspection.

6.9 Most prisoners were serving a long sentence, with 43% serving a life or indeterminate sentence, but there was little dedicated support or

opportunity for them to demonstrate progression. There were no lifer wings or forums, and many prisoners relied on peers for clear information about their sentence. IPP (imprisonment for public protection) forums had just started, but a shortage of registered psychologists meant that prisoners were not always getting the necessary support (see paragraph 6.26).

6.10 One of the main ways for prisoners to progress was by obtaining a lower security classification, but many prisoners waited too long for their categorisation reviews because the offender management unit (OMU) was, on average, waiting for 30 days for security information. The decisions we looked at were reasonable, but prisoners were not always involved, which added to their frustration.

6.11 Even when prisoners had achieved their category C classification, very few were able to move to a low security prison because of population pressures and nearly 10% of prisoners were designated category C at the time of the inspection. One man told us his parole eligibility date was approaching and he could not demonstrate a reduction in risk or access interventions to improve his employability. Most prisoners were from a different resettlement area but could not move closer to their family.

6.12 Despite the clear dissatisfaction of this cohort of prisoners with their opportunity to progress, little had been done to explore or understand what could be put in place to mitigate some of their concerns. Moreover, at the time of the inspection, five category D prisoners had waited too long to transfer because no OASys assessment had been carried out or staff shortages had created difficulties in arranging transport.

6.13 There were not enough probation officers and caseloads were high. Contacts between prison offender managers (POMs) and prisoners were infrequent and often only triggered by key events such as parole.

6.14 Lack of contact from the OMU was a common complaint from prisoners and most said they had only had telephone contact. Until recently, probation offender managers had been told they could not go on to the wings for their own safety and there were not enough private interview rooms across the prison. Prisoners were often not consulted at key points in their sentence and were only informed of decisions weeks or months after they had been made.

6.15 Many prisoners arrived at Lowdham Grange with no up-to-date assessments and then waited too long for them to be completed, hindering their ability to access programmes or have well-informed categorisation reviews. In one case, a prisoner had had no assessment or sentence plan for more than a year after their sentence. Most reviews were conducted by telephone, which was inappropriate and meant that prisoners did not feel sufficiently included in the process. However, the quality of assessments that we reviewed was mainly of a good standard and demonstrated thorough analysis.

6.16 Strategic work to understand the needs of the population and improve outcomes had been too slow to restart following the changeover to HMPPS. There was no up-to-date reducing re-offending strategy. The prison had only just started to pull together data for a needs analysis and had introduced partnership meetings only in the last two months.

Public protection

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

6.17 At the time of the inspection, 86% of the population were assessed as posing a high or very high risk of harm to others and the prison had made some recent improvements to public protection arrangements, although weaknesses remained.

6.18 All new arrivals were now screened on arrival and potential risks to children and contact restrictions were appropriately identified. A small number of prisoners were placed on monitoring and the decisions we looked at were sound, but there was a two-week delay in listening to calls because security staff were cross-deployed. Concerningly, breaches of contact restrictions were not always actioned because of poor communication between the OMU and security.

6.19 The interdepartmental risk management meeting (IRMM) did not routinely consider all prisoners approaching release and those it did discuss were brought to the meeting so close to release that there was not enough time to resolve outstanding risk management concerns. Attendance at the IRMM was improving but key departments outside the OMU did not attend consistently.

6.20 Some prisoners coming up for release had inadequate risk management plans and not enough was done to escalate concerns or follow up on lack of response from community offender managers (COMs). In a particularly concerning case, a prisoner planned to return to a family home previously deemed unsuitable because of safeguarding risks, but there was no evidence of further action to secure an appropriate alternative. Another prisoner had disclosed a threat to his life, but there were no further enquiries or actions, such as safeguarding checks or police alerts, following this disclosure.

6.21 Poor release planning also contributed to a small number of prisoners being released after their home detention curfew eligibility date, and there was poor oversight by OMU managers. We found that one prisoner had been released on electronic monitoring 141 days after his eligibility date and prison staff were unable to explain why this had happened.

6.22 The MAPPA (multi-agency public protection arrangements, see Glossary) contributions reviewed for some of the riskiest prisoners were generally well considered and analytical, often going beyond the immediate requirements by identifying future risks and suggesting

licence conditions to mitigate them. The assessments demonstrated a strong understanding of the risks that individuals posed, both in custody and on release.

Interventions and support

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

6.23 The programmes team was now fully staffed and a small number of prisoners (54) had completed an accredited offending behaviour programme since April 2024. Prisoners could also now complete 'Kaizen IPV' (for offences involving 'intimate partner violence') on a one-to-one basis, which was positive. The programmes team completed an annual needs assessment and suitable prisoners with a key date in the next 12 months were given the opportunity to complete a programme. However, the lack of information about the roll-out of a new programme was making it difficult to plan for delivery beyond the next three months.

6.24 There were few opportunities for prisoners to complete short non-accredited programmes and many prisoners we spoke to were frustrated that they were unable to demonstrate risk reduction, which affected their ability to achieve sentence progression milestones such as re-categorisation. Long-term category C prisoners were especially frustrated by the lack of structured opportunities to develop skills or prepare for release (see paragraph 6.11).

6.25 In the last year, 45 prisoners had completed the Sycamore Tree (victim awareness course) programme run by the chaplaincy and 183 prisoners had completed Behaviour Change and Pro-social modelling courses run by education. However, the lack of an overarching needs analysis and strategy prevented the prison from determining if this was sufficient or if other non-accredited programmes were needed.

6.26 There was only one registered psychologist instead of the five required, and the prison relied on trainee psychologists. This affected the support available for some of the most vulnerable and complex prisoners.

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.

6.27 Although more than 100 prisoners a year were released, there was no structured resettlement function to support re-integration into the community and prisoners were unable to move to their local prison to access the necessary resettlement support (see paragraph 6.11).

6.28 Around half the prisoners were released to supported housing such as approved premises, which was appropriate for their risk. However, a small number (13) were released homeless in the previous year, which was unacceptable when most people had been in the prison for several months. Prisoners did not have access to specialist housing support and relied on their POMs and COMs to complete necessary referrals. Handovers between the prison and community offender managers were often inconsistent, with gaps in risk management planning (see paragraph 6.20). The prison also had poor insight into accommodation outcomes beyond release and did not use data effectively to improve outcomes.

6.29 Finance, benefit and debt support was limited. The DWP attended the prison every two months to help with benefit applications and job centre appointments, but leaders did not know whether this was sufficient to meet the demand. Prisoners could also apply for ID and bank accounts via the OMU, but only very small numbers had used this support and it was not clear how these services were promoted to prisoners. There was also a £10 charge for ID.

6.30 Practical release planning support was reasonably good. The prison had recently introduced a clothing voucher to support prisoners on low incomes or those being released homeless. The OMU had also started to produce easy-read licence conditions for prisoners with additional learning needs which was innovative and good practice.

Section 7 Progress on concerns from the last inspection

Concerns raised at the last inspection

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

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection in 2023, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

Priority concerns

The prison was not safe enough. Outcomes were being undermined by violence, the ready availability of illegal drugs and an inexperienced staff group who lacked the confidence to provide effective supervision and management.
Not addressed

The level of self-harm was high and had risen in recent months. Not enough was being done to support prisoners in crisis and those at risk of self-harm.
Not addressed

Key concerns

There was insufficient oversight and accountability for custody officers, particularly in their use of force. The pervading culture among officers was not focused on responding to prisoner need and the delivery of effective support. Managers did not provide robust oversight to hold officers to account and we were, for example, told about very poor behaviour by some staff working in the segregation unit. Leaders had also failed to investigate serious concerns about the use of force against some prisoners.
Not addressed

Too many prisoners were segregated for long periods without access to a decent and meaningful regime and there were no clear reintegration plans.
Partially addressed

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection in 2023, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

Priority concern

Longstanding staff shortages in health care resulted in lengthy waits for services and some poor outcomes for patients. This was exacerbated by limited strategic support and a lack of governance over the service.
Not addressed

Key concerns

Arrangements to meet the needs of prisoners with protected characteristics were weak.
Not addressed

Partnership working between the health care provider and the prison was poor. The clinical judgment of health care staff was sometimes ignored; this included a lack of investigation into several serious safeguarding concerns they had raised.
Not addressed

The applications and complaints systems were not fully effective and consultation with prisoners led to relatively few changes in practice.
Not addressed

Purposeful activity

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

At the last inspection in 2023, we found that outcomes for prisoners were poor against this healthy prison test.

Priority concern

There were not enough places in education, skills and work for the population. Allocations took too long and were not informed by prisoners' career goals.
Not addressed

Key concerns

The education, skills and work curriculum was too narrow and lacked ambition. There was no reading strategy. Most accredited programmes were only available at level 1 and below. In work, prisoners could not acquire accredited qualifications.
Addressed

Leaders did not make sure that prisoners with additional learning needs had the support they needed. In nearly all cases that identified an additional learning need, further detailed assessments had not taken place.
Addressed

Rehabilitation and release planning

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.

At the last inspection in 2023, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

Priority concerns

There were not enough opportunities for prisoners to complete offending behaviour work and other programmes aimed at reducing their risks.
Partially addressed

Public protection processes were not robust. Too few prisoners had been assessed for their suitability to have contact with children. Managers did not have a comprehensive understanding of all emerging risks and could not therefore manage them effectively. Public protection and pre-release arrangements were not good enough.
Partially addressed

Key concern

The number of prisoners being released was increasing, but the prison had no dedicated resettlement staff or provision for housing support.
Not addressed

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 concerns from the previous inspection.

All inspections of prisons are conducted jointly with Ofsted or Estyn (Wales), the Care Quality Commission 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 concerns raised at the previous inspection and our assessment of whether they have been addressed.

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
Hindpal Singh Bhui	Team leader
Rachel Badman	Inspector
Martin Kettle	Inspector
Dawn Mauldon	Inspector
Alice Oddy	Inspector
Chelsey Pattison	Inspector
Tareek Deacon	Researcher
Helen Ranns	Researcher
Alicia Grassom	Researcher
Phoebe Dobson	Researcher
Shaun Thomson	Lead health and social care inspector
Sarah Goodwin	Health and social care inspector
Craig Whitelock-Wainwright	General Pharmaceutical Council inspector
Dayni Johnson	Care Quality Commission inspector
Martin Ward	Ofsted inspector
Teresa Kiely	Ofsted inspector
Matt Hann	Ofsted inspector
Vicki Locke	Ofsted inspector
Dionne Walker	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.

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.

Family days
Many prisons, in addition to social 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.

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).

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.

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).

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 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)

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