Report on an independent review of progress at

HMP & YOI Deerbolt

by HM Chief Inspector of Prisons

13–15 October 2025

Contents

Section 1 Chief Inspector's summary

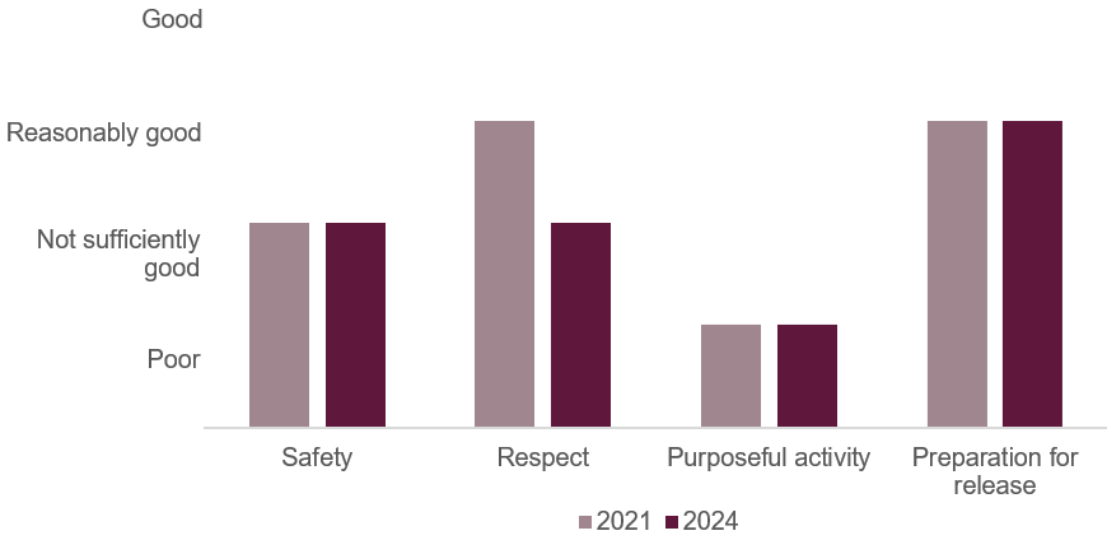
1.1 HMP & YOI Deerbolt, situated near Barnard Castle in County Durham, is a category C training prison for up to 490 adult men. Dating mostly from the 1970s, the prison is a campus-style institution with nine accommodation units.

1.2 This review visit followed up on the concerns we raised at our last inspection of HMP & YOI Deerbolt in December 2024.

What we found at our last inspection

1.3 At our previous inspections of HMP & YOI Deerbolt in 2021 and 2024, we made the following judgements about outcomes for prisoners.

Figure 1: HMP & YOI Deerbolt healthy prison outcomes in 2021 and 2024
Note: rehabilitation and release planning became 'preparation for release' in October 2023.



1.4 At our last inspection of HMP & YOI Deerbolt, we found that while the prison had potential, progress across key areas remained disappointing. Safety continued to be a significant concern, with high levels of violence and a deeply embedded drug culture. The response to self-harm was inconsistent, with support available for some individuals but lacking for many others. Although some improvements were noted in segregation and oversight of use of force, they were not yet robust.

1.5 Health care provision had not kept pace with the changing population and demand, which, combined with a staff shortage and insufficient support from prison staff, had led to a fragile health service.

1.6 Staff–prisoner relationships were undermined by staff inexperience and a restrictive and poorly structured regime, contributing to frustration and disengagement among prisoners. Education, skills and work provision was rated as inadequate by Ofsted.

What we found during this review visit

1.7 Overall, leaders (see Glossary) had made good efforts to address the concerns we raised at the last inspection, with all but two concerns receiving a rating of reasonable progress or better.

1.8 While there had been commendable efforts to reduce the supply and use of drugs, progress had been limited. The slight decline in the number of positive drug tests since the inspection was a step in the right direction, but it was far from sufficient. Tackling the entrenched drug culture will require sustained focus, consistent leadership and the allocation of meaningful resources.

1.9 Levels of violence and self-harm were still high overall, but there had been a notable decline through targeted action that had led to meaningful change.

1.10 There had been a marked improvement in the enablement of health services, which were now reliable and consistent overall, and both prison and health care leaders were working well collectively to continue this effort.

1.11 Significant staffing shortfalls remained a barrier to enabling a consistent day-to-day routine for prisoners. While regional and national leaders were providing support by bringing in staff from other establishments, uncertainty about the future visa status of those recruited from overseas was the key risk to future progress.

Charlie Taylor
HM Chief Inspector of Prisons
October 2025

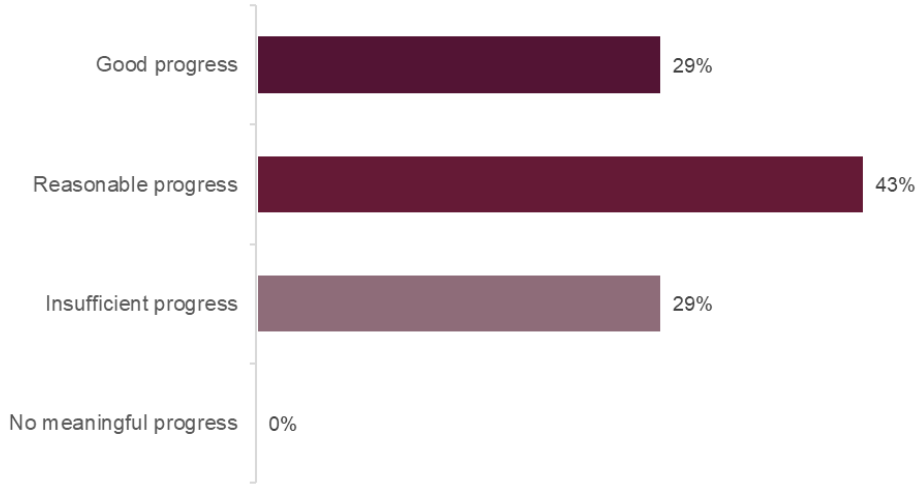
Section 2 Key findings

2.1 At this IRP visit, we followed up seven concerns from our most recent inspection, in December 2024, and Ofsted followed up four themes.

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

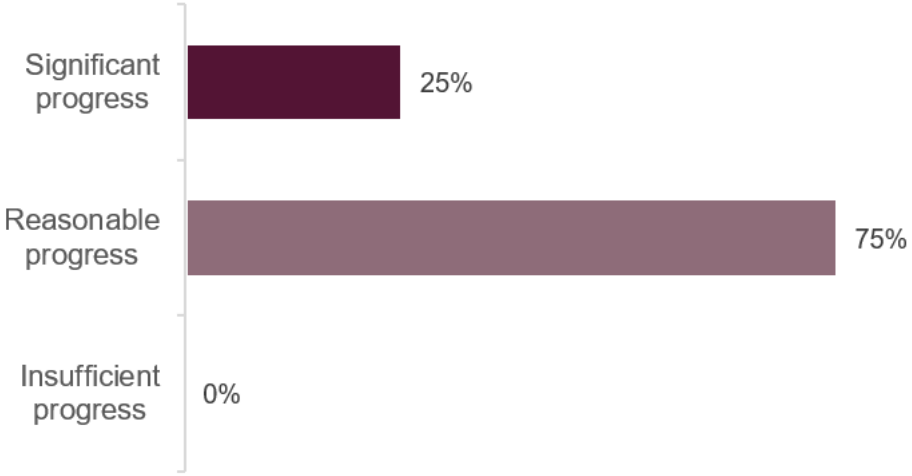
Figure 2: Progress on HMI Prisons concerns from December 2024 inspection (n=7)

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



2.3 Ofsted judged that there was significant progress in one theme and reasonable progress in three themes.

Figure 3: Progress on Ofsted themes from December 2024 inspection (n=4).



Notable positive practice

2.4 We define notable positive practice as:

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

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

Examples of notable positive practice		
a)	The employment advisory board had established strong connections with a range of national and regional employers. This had resulted in a number of employer-led short courses being developed and offered to prisoners. Some prisoners had gained employment as a result.	See paragraph 3.49
b)	Careers guidance workers used particularly effective systems to support prisoners nearing release to research live job vacancies that identified the location, region, salary and any specific personal attributes required by applicants.	See paragraph 3.67

Section 3 Progress against our concerns and Ofsted themes

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

Security

Concern: Illicit drugs were too easily available and the rate of positive random drug tests was high, but leaders had not put in place a coordinated or effective drug strategy.

3.1 The random mandatory drug testing positive rate remained high, and broadly similar to that found at the previous inspection, with 36% testing positive in the last six months, compared to 38% previously. In the months following the inspection, the rate had risen further, peaking at 50% in January 2025. However, recent data showed a downward trend, suggesting that efforts to reduce drug use were beginning to have an impact. In the last three months, the average positive rate had fallen to 30%.

3.2 There had been two suspected drug-related deaths during 2025, and investigations were ongoing at the time of this visit.

3.3 There was now a comprehensive drug strategy, which was well informed by consultation with several substance misuse support agencies in the community and prisoners at Deerbolt.

3.4 A well-attended joint security and drug meeting took place each month, regularly chaired by the governor. This meeting addressed both supply routes for drugs and the illicit economy in the prison, alongside support and challenge for those prisoners who were involved in drug supply and misuse.

3.5 There had been improvements to physical security measures around the prison since the inspection. There was now upgraded closed-circuit television in the visits room, and the governor had funded new, enhanced gate security procedures, whereby every member of staff and all visitors were searched before entry to the prison.

3.6 The day-to-day response to intelligence on drug ingress and use remained inadequate. Staff shortages meant there were not enough resources to search or test prisoners in response to intelligence received. Although there was a triage system to prioritise urgent reports, the overall response lacked the rigour needed to address the scale of the issue effectively.

3.7 A second incentivised substance-free living unit had been introduced on A wing, accommodating up to 60 prisoners. These units were well

regarded by those living on them and were a positive initiative to promote drug-free living. Prisoners told us that the additional incentives, such as increased time out of cell and improved facilities, such as a dedicated exercise room, supported their efforts to remain substance free.

ISFL association areas and art and craft room

3.8 There were also several new interventions, including sessions held by both Alcoholics Anonymous and Narcotics Anonymous. The strength, treatment, empowerment and progress (STEP) programme was an intervention designed to help encourage abstinence.

3.9 One-to-one engagement with the drug and alcohol recovery team had been well promoted and had increased substantially, with around 250 prisoners currently accessing its services.

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

Promoting positive behaviour / use of force

Concern: Levels of violence and force were high and governance of use of force was not sufficiently robust.

3.11 Levels of violence remained high, when compared to similar establishments, but had reduced by 24% since the inspection. In the last six months, there had been 69 assaults on prisoners, and 58 on staff.

3.12 The perception of safety had improved since the inspection, with both staff and prisoners telling us that they felt safer.

3.13 The weekly safety intervention meeting had been expanded and was now a key component of the prison's violence reduction strategy. The meeting maintained a strong focus on identifying and managing prisoners involved in violent behaviour, as well as those considered at risk of becoming involved. This preventative approach enabled staff to discuss emerging concerns and agree targeted actions to reduce the prevalence of violence.

3.14 Several new interventions had been introduced, most notably an 'alternatives to violence' course, which had had significant uptake; 22

prisoners had already completed the course and a further 28 were currently taking part.

3.15 Violence reduction peer mentors had also been introduced and had been trained in conflict resolution. Those we spoke to said that this was a challenging role but that they were well supported, with regular meetings and good access to the safety team.

3.16 Challenge, support and intervention plans (see Glossary) were used effectively to manage and challenge prisoners involved in violence. Plans were applied to both perpetrators and victims, and also, as a preventative measure, to those considered vulnerable to being drawn into violent behaviour, particularly where illicit drug use was a contributing factor.

3.17 The overall level of force used by staff remained high, and similar to that recorded at the inspection, with 468 incidents in the last six months. However, oversight and governance had improved significantly.

3.18 At the time of the inspection, we could not be confident that leaders were consistently aware of all incidents involving the use of force. A full-time use of force coordinator had since been appointed, who made sure that every incident was recorded and that staff statements were submitted promptly. The coordinator also undertook quality assurance of documentation, helping leaders to make sure that the use of force was justified and proportionate.

3.19 The duty governor now triaged every use of force the following day. Concerns or complaints were subsequently reviewed at the weekly use of force meeting, along with a random selection of spontaneous incidents and every use of PAVA incapacitant spray (see Glossary) and batons.

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

Suicide and self-harm prevention

Concern: The rate of self-harm was higher than other similar prisons and mechanisms to provide support, such as ACCT case management and the Listeners scheme, were not being used effectively.

3.21 While the level of self-harm remained high compared with that at similar prisons, it had reduced substantially, by 30%, since the inspection. In the previous six months, there had been 259 incidents of self-harm.

3.22 A second full-time safety officer had been appointed, and the safety team prioritised support for prisoners in crisis or those who were particularly vulnerable, such as prisoners who were isolating for their own safety. They saw around 45 prisoners on a one-to-one basis each

week, including all those who were being supported through the assessment, care in custody and teamwork (ACCT) case management process for prisoners at risk of suicide or self-harm.

3.23 Prisoners told us that they valued this additional support and that they felt cared for while in crisis. The addition of in-cell activity and distraction material, such as therapeutic art, was also appreciated.

3.24 The quality of ACCT documents had improved, with care planning and the identification of triggers for self-harm better than we usually see. Leaders attributed this to both training and improved quality assurance.

3.25 Access by Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) to those in crisis had also improved, and the number of times their services were used had increased. The Listeners, and the Samaritans who supported and trained them, told us that they had supported around 100 prisoners over the past three months.

3.26 The safety club, which we highlighted as notable positive practice at the inspection, continued, and remained popular. We observed prisoners with a long history of self-harm, drug misuse and violence engaging meaningfully with staff and the activities at the club. Some of the prisoners there told us that the additional support they received had directly contributed to their improved well-being and reduction in self-harm.

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

Staff-prisoner relationships

Concern: The over-restrictive regime, inexperienced staff and absence of managers on the wings meant that working relationships between staff and prisoners on the residential units were often poor.

3.28 The new daily routine that had been introduced (see paragraph 3.43) had reduced the need for repeated unlocking and locking up of prisoners during the day, which had previously made the regime cumbersome and challenging for both staff and prisoners. This had also improved prisoner time out of cell (see Glossary). As a result, staff had more time to spend with prisoners.

3.29 Staff inexperience remained, with just over half of officers having less than two years' experience. To mitigate this, leaders had delivered frequent training sessions, covering issues such as the basic tasks of an officer and professional conduct, to build both confidence and capability. In addition, a new colleague mentor had been in post since August 2025, to support newly appointed officers.

3.30 Staff repeatedly told us that leadership visibility on some wings was limited. Senior officers and custodial managers were often unavailable because of meetings, managing incidents and other tasks, reducing the

support they could give officers, particularly at key times of the day. Records also demonstrated a limited presence from more senior leaders; for example, one unit had received just a third of scheduled daily visits, and these were often brief and sometimes when prisoners were locked up.

3.31 Most prisoners reported good relationships with staff, and our observations supported this. Staff we spoke to were familiar with individual prisoners' needs and we observed meaningful engagement.

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

Health, well-being and social care

Concern: Patients faced unacceptable barriers to receiving health care: there were too few health staff; clinics were often cancelled; patients were not escorted to appointments, including those outside at hospital; and they received medicines late. The problems were compounded by a high number of medical emergencies caused by substance misuse, a shortage of prison officers and regime restrictions.

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

3.34 Prison and health care leaders and staff had worked hard to make sure that barriers to providing health care for patients had been removed. Effective collaboration, demonstrated by well-attended regular meetings, ensured a continued focus on improving patient outcomes.

3.35 There had been clear improvements in enhancing the staffing resource. There was now an agreed staffing model and recruitment was progressing at pace. A core group of agency nurses was now in post and a sessional advanced nurse practitioner provided additional clinical input. The service had not operated below safe staffing levels in the last six months.

3.36 Health care leaders had undertaken a full review of the service model and, as a result, had created more capacity within the team and increased the availability of clinicians. Alongside this, health care staff had introduced zonal working within the prison, whereby patients received care and treatment consistently on the wings, which was positive. Clinics were now rarely cancelled and, overall, attendance at health care appointments had improved. Prison and health care staff worked well to make sure that external hospital appointments were enabled.

3.37 Health care and prison leaders had centralised the administration of controlled medicines to the health care building, which meant that

patients received these in a much more consistent and timely manner. It was positive that methadone was now measured and poured electronically. However, prison officers were providing poor oversight of queues, and leaders agreed that this needed further attention, to prevent bullying and diversion of medicines.

3.38 The regional pharmacist had transformed the process by which patients received their in-possession medicines, from ordering through to supply, so patients no longer faced delays. We spoke to several patients and they were satisfied overall with their ongoing supply of medicines.

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

Concern: Clinical governance of health services was weak. Clinical incidents were not always recorded, health care complaints were not confidential, and patients did not know how to submit a complaint.

3.40 Governance of the service remained a concern. We were not confident that clinical incident reporting had progressed sufficiently. Although staff told us that they had received training on how to report incidents, there were no records of attendance or completion. While the recording of incidents had increased, we still found that not all incidents were reported. This meant that oversight by managers and opportunities to improve patient safety needed improvement.

3.41 Health care complaint forms were now available, and clearly advertised on all wings. Prison staff we spoke to were confident in how to direct patients who wished to complain to use the process. We saw recent complaints being addressed in a timely manner, with the provider focused on early face-to-face resolution.

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

Time out of cell

Concern: The unreliable regime was a huge source of frustration for prisoners. Many prisoners were locked up during the working day, which was especially unacceptable for a Category C training prison, and prisoners struggled to get to places such as health care or activities on time or at all.

3.43 Leaders had introduced a new daily routine in March 2025, increasing time out of cell for most prisoners to seven and a half hours per day, provided that there were no curtailments. Full-time workers could receive an additional couple of hours on two evenings a week. Our time out of cell checks confirmed this improvement, with only 13% of prisoners locked up during the working day, down from 30% at the inspection.

3.44 The quality of the time spent unlocked had also improved, as prisoners had greater freedom to move around the unit and were not confined to the shower room, association room or their cell. The introduction of an open-door policy had enabled them to interact with one another in smaller groups throughout the day. In addition, there were opportunities to engage in enrichment activities (see Ofsted section).

3.45 However, too few prisoners were in purposeful activity. Most worked only part time, as the number of education and work spaces was insufficient for the population, and remained inadequate for a training prison. During our roll check, we found only 40% of prisoners undertaking purposeful activity, which was similar to the level at the time of the inspection.

3.46 There were significant staffing shortfalls, which meant that there were often curtailments to the regime, particularly at weekends. However, leaders had improved predictability through effective weekly planning meetings, held by the deputy governor, with the outcome communicated in advance. As a result, prisoners were less frustrated than at the time of the inspection.

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

Education, skills and work

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

Theme 1: The curriculum for education, skills and work (ESW) was not sufficiently broad to meet the needs of the prison population and did not enable prisoners to develop the knowledge and skills they needed to prepare for release. In addition, attendance was too low in ESW and prisoners too often arrived late.

3.48 Leaders and managers had taken positive action to extend the curriculum. Regional and national labour market intelligence and the demographic of prisoners' ages and sentences had been used well to align new courses with prisoners' needs and labour market skills shortages.

3.49 The employment advisory board had established strong partnerships with national and regional employers to develop new training courses in construction, traffic management and employment-related skills. These

courses benefited from input by employers and their subcontractors, who shared industry insights with prisoners. A key feature of the courses was the inclusion of practical experience. For example, operating a road digger, using a simulator, allowed prisoners to gain hands-on experience with heavy plant machinery in a safe and controlled environment. These courses were popular among prisoners and had had a notably positive impact on their motivation and aspirations. The initiative had already resulted in some positive job outcomes.

3.50 Leaders and managers had advanced plans to introduce a new industries workshop within the prison, which would be run by three employers. Prisoners would benefit from employer-led sessions that not only delivered industry-relevant skills, but also facilitated direct pathways to employment on release. In education, managers had expanded the range of vocational training to include a brickwork course, and had also increased access to English and mathematics support by offering it in three workshops. However, one vocational workshop was currently closed due to staffing issues.

3.51 Attendance and punctuality had improved but were not consistently good. Leaders and managers monitored attendance and punctuality daily, holding prison officers accountable when they did not make sure that prisoners attended assigned activities. To help improve attendance, a designated senior officer now acted as a link between ESW and wing staff, with authority to help enforce participation. A progress coach supported prisoners with poor attendance. However, in education, frequent class cancellations due to a lack of staff cover, and sporadic closures of all activities by prison leaders due to staff shortages continued to have a negative effect on attendance.

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

Theme 2: Too much teaching in vocational training was weak. Leaders and managers had not identified the weaknesses in the quality of teaching and had not taken effective actions to make improvements.

3.53 Leaders and managers applied well-thought-out quality assurance measures with rigour and clearly identified areas where improvement was needed.

3.54 Following the inspection, managers had introduced a range of professional development activities across ESW. In education and vocational training, the focus was on improving the craft of teaching. Following training and support measures being put in place, and giving teachers and tutors time to embed best practice, managers undertook ‘learning walks’ to measure improvements and impact on prisoners. Some staff welcomed the support and enthusiastically applied their training in the planning and teaching of their sessions. However, others

were more resistant to changing their practice, and in these instances improvement had been slow.

Vocational workshops

3.55 In prison industries, well-planned weekly staff development sessions had provided instructors with the skills and tools needed to plan effective training, and to set and review improvement targets for prisoners. As the training programme had progressed, instructors had grown in confidence and were able to identify individual issues with which they were struggling. Some of these related to training, but others were related to their understanding of prison procedures and how they applied these to prison industries. As a result of the targeted support provided, instructors understood how to plan activities, use the 'progress to work' booklet to monitor skill development and set improvement targets, and to apply prison procedures effectively and with confidence.

3.56 In prison industries, prisoners worked well together. They understood their work targets and valued the feedback from instructors on what they had done well and what skills still needed to be developed. In education classes, prisoners worked diligently and showed care in the work they produced. For example, in a barbering class, they took care with their spelling and grammar, and confidently asked for support to check their work for accuracy, particularly with technical vocabulary.

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

Theme 3: Leaders and managers had not implemented an enrichment curriculum that all prisoners could access. They had set up a range of useful activities on one residential wing but not on the remainder, so too few prisoners benefited from enrichment.

3.58 At the time of the inspection, enrichment activities had been offered on only one specialist unit. Since then, both the scope and frequency of enrichment activities had increased.

3.59 Leaders and managers had introduced a programme of enrichment in June 2025, in which prisoners on every wing could participate. They had planned a varied timetable, with the input of staff and prisoners,

and worked with staff to support them to deliver it. The programme aimed to broaden prisoners' experiences, develop essential personal and social skills and resilience, and foster new interests. Attendance at these sessions was generally high, reflecting a positive response from prisoners. However, staff shortages sometimes meant that not all prisoners who wished to participate could do so, as there were not sufficient officers available to unlock and supervise them.

3.60 Activities were varied and interesting, and included team building, food hygiene, chess and tai chi for beginners. A range of craft activities was aimed at developing new skills, such as clay modelling, card making, and matchstick and three-dimensional modelling, and prisoners enjoyed participating. One prisoner stated that he enjoyed making matchstick models, as he could give them to his children during family visits. Others said that activities improved their mental health and general well-being. However, while prisoners' views were sought on their level of enjoyment and any other activities they would like to see offered, managers did not assess the wider skills that prisoners developed, such as communication, problem solving and teamwork, or get the prisoners to reflect on their own development of these skills.

3.61 In education, managers had established partnerships to extend enrichment opportunities. For example, they hosted a tile design masterclass led by a professional designer. Learners in construction crafts gained new techniques relevant to their course and were encouraged to develop and apply their skills creatively. An annual project with the Bowes Museum developed prisoners' creative skills by making models that were linked to a museum project, and were displayed in the museum.

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

Theme 4: Staff did not provide sufficiently helpful or timely ongoing careers guidance for prisoners to support them in their next steps.

3.63 The new provider, Ingeus, which had taken over the contract in 2025, had established effective working practices to make sure that prisoners received good-quality careers advice and guidance, from well-trained staff, at all stages of their sentence.

3.64 The provider had set clear parameters for the frequency of guidance interviews, related to the sentence length of the prisoner. Managers made sure that prisoners received timely and useful advice on their next steps. Staff were flexible in their approach and offered additional interviews on request for those prisoners serving longer sentences.

3.65 The provider had made sure that staff and peer mentors had the skills they needed to carry out their role successfully. They had invested heavily in a wide range of useful staff training and development. For example, guidance workers were undertaking a level 4 qualification in careers guidance, and team leaders were taking a qualification at level

6. Training had included how to use and populate a new personal learning plan, and how to set effective and realistic goals linked to sentence planning and employment on release. Guidance Interviews were well conducted, and targets realistic. Peer mentors completed an effective programme and had developed the skills they needed to be good mentors.

3.66 Staff had worked effectively, early in the contract, to make sure that any outstanding interviews were completed. Managers and guidance staff monitored when prisoners were due for a guidance interview and were efficient in meeting the deadlines.

3.67 Job search systems for prisoners nearing release were highly effective. The information technology platform allowed guidance workers to find jobs quickly by location, salary and required skills. Prisoners could easily log in, use career-matching tools and discover their transferable skills. This was especially helpful for those restricted from certain professions, enabling them to consider alternative careers. Other systems supported CV development.

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

Section 4 Summary of judgements

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

HMI Prisons concerns

Illicit drugs were too easily available and the rate of positive random drug tests was high, but leaders had not put in place a coordinated or effective drug strategy.
Insufficient progress

Levels of violence and force were high and governance of use of force was not sufficiently robust.
Reasonable progress

The rate of self-harm was higher than other similar prisons and mechanisms to provide support, such as ACCT case management and the Listeners scheme, were not being used effectively.
Good progress

The over-restrictive regime, inexperienced staff and absence of managers on the wings meant that working relationships between staff and prisoners on the residential units were often poor.
Reasonable progress

Patients faced unacceptable barriers to receiving health care: there were too few health staff; clinics were often cancelled; patients were not escorted to appointments, including those outside at hospital; and they received medicines late. The problems were compounded by a high number of medical emergencies caused by substance misuse, a shortage of prison officers and regime restrictions.
Good progress

Clinical governance of health services was weak. Clinical incidents were not always recorded, health care complaints were not confidential and patients did not know how to submit a complaint.
Reasonable progress

The unreliable regime was a huge source of frustration for prisoners. Many prisoners were locked up during the working day, which was especially unacceptable for a Category C training prison, and prisoners struggled to get to places such as health care or activities on time or at all.
Insufficient progress

Ofsted themes

The curriculum for education, skills and work (ESW) was not sufficiently broad to meet the needs of the prison population and did not enable prisoners to

develop the knowledge and skills they needed to prepare for release. In addition, attendance was too low in ESW and prisoners too often arrived late.
Reasonable progress

Too much teaching in vocational training was weak. Leaders and managers had not identified the weaknesses in the quality of teaching and had not taken effective actions to make improvements.
Reasonable progress

Leaders and managers had not implemented an enrichment curriculum that all prisoners could access. They had set up a range of useful activities on one residential wing but not on the remainder, so too few prisoners benefited from enrichment.
Reasonable progress

Staff did not provide sufficiently helpful or timely ongoing careers guidance for prisoners to support them in their next steps.
Significant progress

Appendix I About this report

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

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

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

The aims of IRPs are to:

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

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

IRP methodology

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

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

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

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

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

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

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

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

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

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

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

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

Inspection team

This independent review of progress was carried out by:

Donna Ward	Team leader
David Foot	Inspector
John Wharton	Inspector
Shaun Thompson	Health and social care inspector
Gee Walker	Care Quality Commission inspector
Joanne White	Care Quality Commission inspector
Sheila Willis	Ofsted inspector

Appendix II Glossary

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

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

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

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.

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

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

Appendix III Care Quality Commission action plan request

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The inspection of health services at HMP & YOI Deerbolt was jointly undertaken by the CQC and HMI Prisons under a memorandum of understanding agreement between the agencies (see Working with partners – HM Inspectorate of Prisons (justiceinspectorates.gov.uk)). The Care Quality Commission issued requests for action plans following this inspection.

Breach of Regulation

Provider: Spectrum Community Health C.I.C.
Location: HMP & YOI Deerbolt
Location ID: 1-8566841446
Regulated activities: Diagnostic and Screening Procedures Treatment of disorder, disease or injury

Regulation 17 Good governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulations for service providers and managers - Care Quality Commission (cqc.org.uk)

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

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

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

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

c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment

provided to the service user and of decisions taken in relation to the care and treatment provided;

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

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

(ii) the management of the regulated activity;

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

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

How the regulation was not being met

- Systems and processes were not always effective for assessing, monitoring and improving the quality and safety of the services provided.
- Incidents were not consistently reported, with notable delays and omissions in recording incidents.
- Managers had introduced processes to track delayed or incomplete reporting. However, these mechanisms were ineffective and lacked sufficient oversight from leaders.
- The service had not maintained accurate records of supplementary or ad hoc refresher training for staff.
- Staff and managers told us about incident reporting practices that indicated under-reporting. This hindered the service's ability to analyse trends, identify learning for improvement, and maintain accurate and complete records.
- Key meetings that formed part of the service's governance structure did not consistently fulfil their intended functions and did not demonstrate robust governance, oversight and assurance.

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

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