



Report on an independent review of progress at

## **HMP Thameside**

by HM Chief Inspector of Prisons

12–14 January 2026



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## Section 1 Chief Inspector's summary

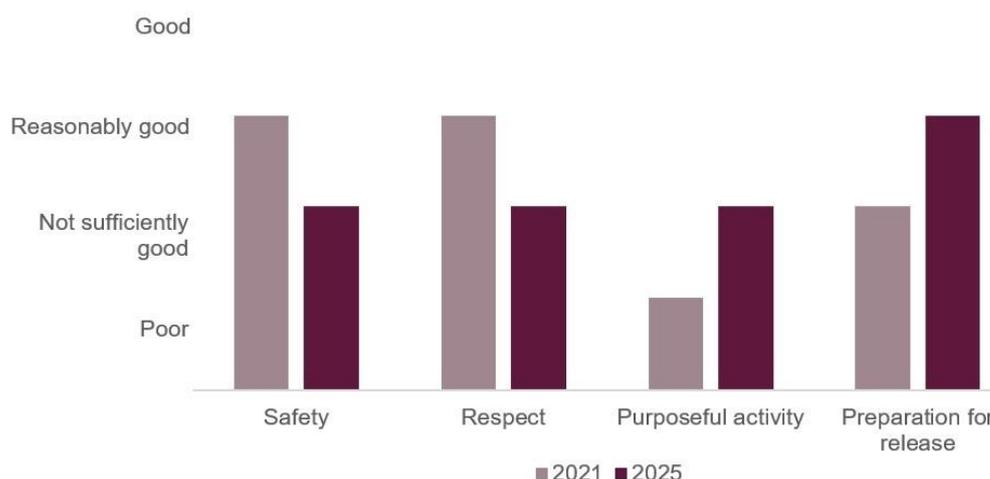
- 1.1 HMP Thameside is a large, modern men's reception prison located in south-east London. It was built in 2012 and is operated by Serco Justice and Immigration as part of a 25-year contract. The prison holds around 1,200 men and the population changes rapidly, with about 100 arrivals every week.
- 1.2 This review visit followed up on concerns we raised at our last inspection in February 2025.

### What we found at our last inspection

- 1.3 At our previous inspections of HMP Thameside in 2021 and 2025 we made the following judgements about outcomes for prisoners.

**Figure 1: HMP Thameside healthy prison outcomes in 2021 and 2025**

Note: rehabilitation and release planning became 'preparation for release' in October 2023



- 1.4 At the inspection in February 2025, we found that outcomes in our healthy prison test for 'safety' had deteriorated. Levels of violence had increased, and too much of it was serious in nature. Drugs were too easily available. Prisoners at risk of suicide and self-harm did not get good enough support.
- 1.5 Outcomes in our test for 'respect' had also got worse, principally because of some unusually serious weaknesses in health care. Leadership and governance were both poor, and this had led to real concerns about patient safety. Many aspects of primary care were not good enough and the prison did not have an up-to-date assessment of its population's health needs. Men needing to be transferred to a secure hospital waited much too long.

- 1.6 Although outcomes in our ‘purposeful activity’ test had improved, not enough men were allocated to activities, and attendance was low. The quality of teaching needed improvement.

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

- 1.7 At this review visit, the prison had a new director and deputy director. There was also a new head of education, skills and work, as well as new leaders in health care and safety. They had all begun to drive progress and we were impressed by how seriously they had taken our concerns.
- 1.8 In particular, the serious deficiencies in health care had been tackled with vigour by its new leaders and a huge amount had been achieved in less than a year. Health care staff spoke well of the changes that had been made, and prisoners were no longer exercised by the health care service, as they had been at the inspection. We found good progress against three of the four concerns we reviewed in this area.
- 1.9 Progress in addressing our concerns about safety had been slower. Levels of violence between prisoners remained stubbornly high and too much of this was still serious. Although there were now more consequences for poor behaviour, the prison offered little to incentivise prisoners to behave well. Drugs were still too easily available, and the random mandatory drug testing rate was unchanged. The prison also sorely lacked enhanced gate security, something other reception prisons have been given. Leaders had made reasonable progress in improving support for those at risk of self-harm or suicide, and they had paid good attention to improving care planning for these prisoners.
- 1.10 Ofsted considered that reasonable progress had been made against the two themes it revisited. Allocation processes to get men into activities had improved, but attendance was still too low. There had been some notable efforts to improve the quality of teaching.
- 1.11 Overall, the new leaders at Thameside can be proud of their achievements since the inspection. There is still a lot of work to do; in particular, to make the prison safer and get more men into daily purposeful activity. However, their work to improve Thameside, while also dealing with a large, constantly changing remand population, was commendable.

**Charlie Taylor**

HM Chief Inspector of Prisons

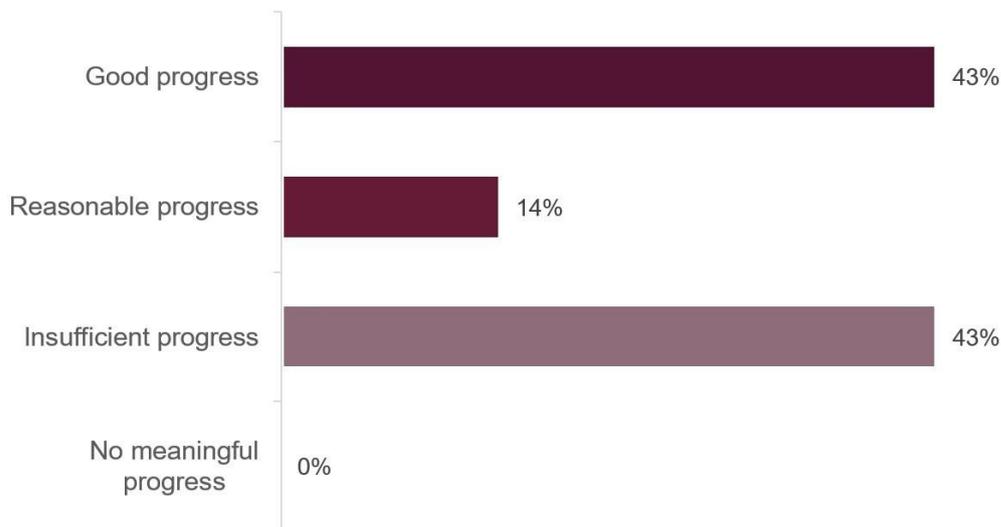
January 2026

## Section 2 Key findings

- 2.1 At this IRP visit, we followed up seven concerns from our most recent inspection in February 2025 and Ofsted followed up two themes.
- 2.2 HMI Prisons judged that there was good progress in three concerns, reasonable progress in one concern and insufficient progress in three concerns.

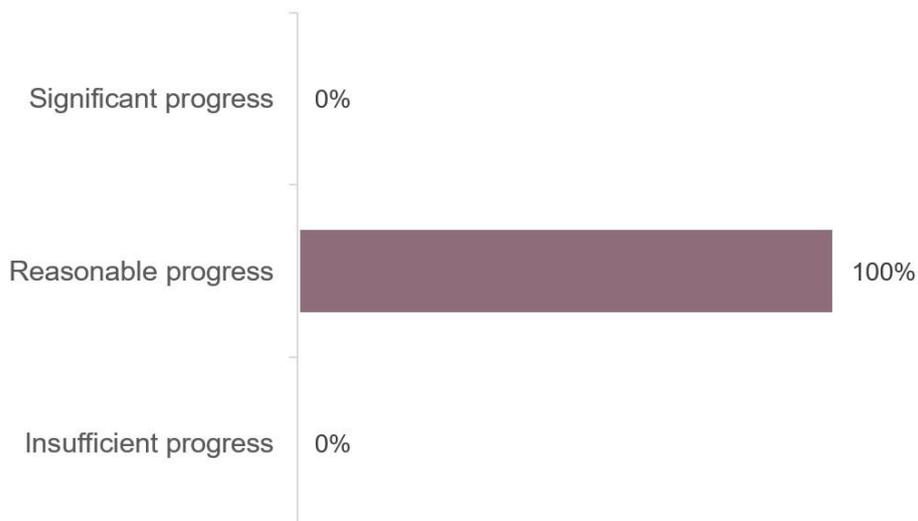
**Figure 2: Progress on HMI Prisons concerns from 2025 inspection (n=7)**

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 reasonable progress in the two themes it reviewed.

**Figure 3: Progress on Ofsted themes from 2025 inspection (n=2).**



## Notable positive practice

2.4 We define notable positive practice as:

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

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

### Example of notable positive practice

- a) A multi-disciplinary review was undertaken for every patient who arrived at Thameside. This ensured their health needs were fully identified and prompt treatment was offered. See paragraph 3.26

## 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 2025.

### Safety

**Concern:** The frequency and severity of violence were too high. Low-level poor behaviour went unchallenged, and the adjudication system was mostly ineffective.

- 3.1 The overall rate of prisoner-on-prisoner violence remained high and was similar to the last inspection. The proportion of assaults that were serious was currently among the highest amongst reception prisons.
- 3.2 Levels of violence against staff had, however, fallen since the inspection, and this meant that there had been a slight reduction in the level of violence overall.
- 3.3 The regime was better than most reception prisons. The many prisoners without purposeful activity were allowed out of their cells for several hours a day. This helped to ease any frustrations. Most men we spoke to reported feeling reasonably safe, and wings felt relatively well controlled, despite the inexperience of many staff.



Houseblock 1 and the football pitch

- 3.4 Prisoners who carried out violent acts were now more likely to experience consequences because the backlog of adjourned adjudications had reduced from around 180 at the inspection to 33 during this visit. Outstanding police referrals had now been substantially dealt with because of improved relationships between the prison and the police.
- 3.5 Leaders had strengthened the safety team, and safety officers were no longer frequently cross-deployed to other duties. They had recently started to consult prisoners to better understand the causes of violence.
- 3.6 Challenge, support and intervention plans (CSIPs) were still not used effectively. Typically, reviews were not multidisciplinary, targets were generic and prisoners we spoke to were not aware of the behaviour that was expected of them.
- 3.7 We continued to see examples of low-level poor behaviour, such as vaping on the landings, going unchallenged by staff. Oversight of prisoners who were self-isolating because they feared for their safety was still lacking.
- 3.8 Leaders had yet to implement a broader range of incentives on wings to promote positive behaviour.
- 3.9 We considered that the prison had made insufficient progress against this concern.

**Concern:** The use of drugs was too high. In random mandatory drug tests a quarter of prisoners had tested positive in the last year.

- 3.10 Prison data showed that the number of prisoners being found under the influence of drugs in recent months was low. However, the random mandatory drug testing rate across the last six months was 25%, identical to a similar period before the inspection. Some prisoners told us that drugs were still easily available.
- 3.11 Positively, there was no longer a backlog of intelligence reports waiting to be processed in the security department. A full lock-down search of all cells had been completed in recent months, drug detection dogs were being put to better use, and there was a good focus on searching social visitors. These actions had all resulted in useful finds.
- 3.12 However, not enough suspicion drug tests were completed in response to intelligence. Not enough staff searches were completed either. The prison conducted random searches of some staff when they arrived for work. However, proper funding for a comprehensive approach to gate security had yet to be confirmed.
- 3.13 The Rapiscan machine, which is normally used to detect illicit substances which have been impregnated into letters and other mail

items, had been broken for several months. However, the process for managing Rule 39 mail was now robust.

- 3.14 We considered that the prison had made insufficient progress against this concern.

**Concern:** Care for prisoners in crisis was not good enough. ACCT documents did not offer suitable support for prisoners in crisis and there was insufficient input in their management from health care professionals.

- 3.15 The recorded rate of self-harm had reduced steadily since the last inspection. There had been 28% fewer incidents over the past six months compared with the same period before the inspection. There had been one non-natural death since the last inspection, which still awaited classification.
- 3.16 Managers had been upskilled to better oversee assessment, care in custody and teamwork (ACCT) processes, and quality assurance had been strengthened. Overall, the quality of the ACCT care plans and associated actions that we looked at had improved and was now reasonably good.
- 3.17 However, successive ACCT case reviews were rarely completed by the same case manager, which did not support good continuity of care. Although mental health staff now typically attended the first case review, most other reviews were still not multidisciplinary, and we found some examples where input from health care staff would have been beneficial.
- 3.18 Most prisoners currently receiving ACCT support told us they felt cared for by staff. The regime was better than most other reception prisons, and they appreciated the time out of their cells. However, they were often bored and few had anything purposeful to do.



### Houseblock 1 D wing uppers

- 3.19 There was no published strategy to reduce self-harm. Actions to reduce levels of self-harm were now generated in the monthly safety meeting, and a tracker to monitor progress had recently been introduced.
- 3.20 There was still no Listener scheme in place, but leaders were working with the Samaritans to restore one.
- 3.21 We considered that the prison had made reasonable progress against this concern.

### Health care

**Concern:** The previous requirements for improvements imposed by the health care regulator in 2024 had not been addressed. Inconsistent leadership and failing governance had led to inadequate management of complaints, poor record keeping in primary care and mental health, and deficiencies in recording medicines. This fundamentally undermined patient safety.

- 3.22 The CQC warning notices issued after the inspection had now been rescinded.
- 3.23 Impressive new leaders had come into post since the inspection. They had taken concerted action to address our concerns and drive change, while also understanding the remaining challenges. There were clear improvements in patient care.
- 3.24 Staffing had improved. Frontline health care staff felt respected and listened to, and received better supervision and access to training and

learning opportunities. These covered themes that had emerged from the improved incident management and reporting systems now in place.

- 3.25 Governance and oversight were now robust, which ensured that our previous concerns about patient safety were now managed effectively and clinical care standards were met.
- 3.26 There was a stronger focus on identifying patients' health needs on arrival, so that they got the right care to begin with. Every new arrival was discussed at a multidisciplinary review.
- 3.27 Areas criticised at the last inspection had improved: waiting times for most clinics were shorter; the service was now responsive and flexible, for example wing-based clinics had been introduced; complaints management was much better; and medicines were generally supplied in a timely manner.
- 3.28 We considered that the prison had made good progress against this concern.

**Concern:** Several components of primary care administration and practice were inconsistent, so the needs of patients were not being fully met.

- 3.29 The overall standard of primary care services had improved. Clinical oversight of the service was now robust and delivered by a skilled staff group who had worked hard to improve the service.
- 3.30 Leaders had implemented effective governance processes. This had contributed to better patient outcomes, particularly relating to long-term conditions (LTC) and wound care.
- 3.31 There were now regular LTC clinics. Care plans were more detailed and personalised – showing evidence of patient involvement – and were reviewed regularly. An LTC nurse had been recruited and worked well with the GP and other nurses to provide a good standard of care.
- 3.32 Patients with wounds now received a detailed assessment. Care plans clearly set out the interventions needed and progress was recorded appropriately.
- 3.33 Prisoners could now apply to health services using in-cell technology. Applications were reviewed promptly and prioritised appropriately.
- 3.34 The management and oversight of external hospital appointments had been overhauled and were much more effective. Partnership working between Practice Plus Group and prison leaders helped to manage hospital appointments more smoothly. Some hospital appointments were still cancelled. This was usually because the patient refused to attend, but sometimes it was due to a lack of prison escort staff.

- 3.35 We considered that the prison had made good progress against this concern.

**Concern:** There was no up-to-date health needs assessment.

- 3.36 In the course of addressing our concerns, leaders had already identified key areas of clinical risk and sought further investment to address these gaps. NHS England had subsequently approved a business case for additional staff, and this had already significantly improved clinical care.
- 3.37 NHS England were developing a more detailed health needs analysis. This was expected to be published in the next few months and would identify any further areas of unmet need.
- 3.38 We considered that the prison had made good progress against this concern.

**Concern:** Patients needing care in a mental health hospital waited too long to be transferred.

- 3.39 A new transfer and remissions lead sought to expedite transfers under the Mental Health Act wherever possible, and there was evidence to suggest her work was having a positive impact. The average waiting time from referral to transfer had reduced. However, it was currently 66 days, which was still far too long.
- 3.40 Over the last year, there had been 29 transfers to hospital under the Mental Health Act. Only a handful had proceeded within the recommended timescale of 28 days. We found examples of prisoners being held in the prison as a place of safety past their release date, because they were so profoundly unwell and a Mental Health Act transfer had not been arranged in time.
- 3.41 We considered that the prison had made insufficient progress against this concern.

## 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:** What progress have leaders and managers made in ensuring more prisoners are allocated and attend activities?

- 3.42 Leaders had considered carefully their new allocations process which they had implemented successfully. As a result, prisoners were allocated to activities more effectively.
- 3.43 Staff risk-assessed all prisoners on arrival to ascertain if there were any areas of work to which they are not suited. As a result, by the time they had their careers education, information, advice and guidance meeting as part of their induction, staff understood what roles would be suitable for each prisoner, thereby speeding up allocations.
- 3.44 Staff now have a single allocations list which, alongside the new regime, made it clear when prisoners were available for education, skills and work. This allowed for prisoners to be allocated to both work and education, without them having to choose which one to attend. Furthermore, fewer prisoners missed lessons due to legal or social visits.
- 3.45 While the proportion of prisoners allocated to activities had increased to approximately 75%, too many were still not routinely allocated to activities. This had led to waiting lists on most courses.
- 3.46 Attendance had started to improve and was on an upward trajectory. However, during the inspection, attendance at activities was not consistent with the prison's own data. Where prisoners did not attend activities, prison officers did not always challenge this. Attendance in education was better than in vocational classes.
- 3.47 Ofsted considered that the prison had made reasonable progress against this theme.

### **Theme 2:** What progress have leaders and managers made in improving the quality of teaching across education, skills and work?

- 3.48 Leaders had recruited several new tutors into areas identified at the previous inspection as underperforming. The new tutors in English,

mathematics, digital skills, and English for speakers of other languages (ESOL) had begun to have positive impacts and the quality of teaching had started to improve in these subjects.

- 3.49 Tutors created a calm environment in lessons, which helped prisoners to learn. They did this by setting clear expectations for behaviour. Prisoners within lessons called out others' behaviour if it was not of the required standard.
- 3.50 Tutors planned lessons that were engaging and supportive. They used a range of mostly effective teaching strategies to help prisoners learn. In vocational subjects, less progress had been made in raising standards of teaching. At times, tutors failed to maintain the interest of prisoners who spent too much time unoccupied while others completed practical tasks. Tutors did not structure their questions clearly enough, which led to prisoners being unclear as to what had been asked of them.
- 3.51 Tutors assessed prisoners frequently to check what they had learned, and most provided useful feedback. In a minority of cases, tutors did not provide enough feedback when prisoners got the answer wrong. For example, when prisoners scored low marks for a task, tutors did not explain how they could have achieved a higher score. In written work, tutors did not consistently correct spelling, particularly the use of capital letters. This meant that prisoners often repeated the same mistakes in their work. In some instances in mathematics, tutors incorrectly marked questions as wrong when the answers were correct.
- 3.52 Ofsted considered that the prison had made reasonable 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

The frequency and severity of violence were too high. Low-level poor behaviour went unchallenged, and the adjudication system was mostly ineffective.

#### **Insufficient progress**

The use of drugs was too high. In random mandatory drug tests a quarter of prisoners had tested positive in the last year.

#### **Insufficient progress**

Care for prisoners in crisis was not good enough. ACCT documents did not offer suitable support for prisoners in crisis and there was insufficient input in their management from health care professionals.

#### **Reasonable progress**

The previous requirements for improvements imposed by the health care regulator in 2024 had not been addressed. Inconsistent leadership and failing governance had led to inadequate management of complaints, poor record keeping in primary care and mental health, and deficiencies in recording medicines. This fundamentally undermined patient safety.

#### **Good progress**

Several components of primary care administration and practice were inconsistent, so the needs of patients were not being fully met.

#### **Good progress**

There was no up-to-date health needs assessment.

#### **Good progress**

Patients needing care in a mental health hospital waited too long to be transferred.

#### **Insufficient progress**

### Ofsted themes

What progress have leaders and managers made in ensuring more prisoners are allocated and attend activities?

#### **Reasonable progress**

What progress have leaders and managers made in improving the quality of teaching across education, skills and work?

#### **Reasonable progress**

## Appendix I About this report

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

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

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

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 February 2025 for further detail on the original findings (available on our website at [Our reports – HM Inspectorate of Prisons \(justiceinspectorates.gov.uk\)](https://www.justiceinspectorates.gov.uk/our-reports)).

### IRP methodology

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

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

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

**No meaningful progress**

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

**Insufficient progress**

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

**Reasonable progress**

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

**Good progress**

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

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

**Insufficient progress**

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

**Reasonable progress**

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

**Significant progress**

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

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

## **Inspection team**

This independent review of progress was carried out by:

Jonathan Tickner	Team leader
Natalie Heeks	Inspector
Rebecca Stanbury	Inspector
Maureen Jamieson	Health care inspector
Stephen Eley	Health care inspector
Steve Lambert	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>.

### **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.

### **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.

### **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.

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