



Report on an unannounced inspection of

HMP Swaleside

by HM Chief Inspector of Prisons

1–11 December 2025



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Introduction

Our inspection of Swaleside, a category B training prison on the Isle of Sheppey, revealed a prison in disarray, with the lowest scores in my five years as chief inspector. Containing 879 men, most of whom were serving long or indeterminate sentences, levels of violence were some of the highest of any prison in England and Wales and assaults on staff, many of which were serious, had more than doubled since our last inspection in 2023.

Much of the violence had been driven by the large amounts of drugs being brought into the prison by drones. Drug debts and gang rivalry were often the cause of assaults, and many prisoners were routinely making and carrying weapons.

Long-term difficulties with staffing meant that only three-quarters of officers were available for duty, while a lack of operational support grades meant that enhanced gate security to prevent the ingress of contraband was inconsistent. Morale amongst officers during our inspection was very poor; many looked exhausted and some appeared to have become disassociated from the chaos around them. Amongst staff and prisoners, the constant fear of violence had a corrosive effect on many aspects of prison life, including staff-prisoner relationships. Many prisoners chose not to go to the gym or attend medical appointments because they were frightened; in our survey, 43% of men said they currently felt unsafe. Systems for managing behaviour were almost non-existent, with little in the way of challenge or incentive. Inspectors observed open rule-breaking and even witnessed prisoners pushing through searching lines of officers.

To attempt to regain control, senior leaders from the long-term, high-security estate and the governor had instigated a new regime that was resulting in just over an hour a day out of cell for the 44% of prisoners who were unemployed or retired. A failure by leaders to communicate adequately these changes to staff and prisoners had led to chaotic situations where no one appeared to know what was supposed to be happening. National resources were sent to the prison, including dogs to try to restore order, and during our inspection, 23 troublesome men were shipped to other jails.

Recent cuts to education provision had led to the discontinuation of some vocational courses that had been popular with prisoners. Allocations to activities were far too slow and some workshops did not have enough workers because there were not enough prisoners who passed the risk threshold to use the equipment. The prison was utterly failing to fulfil its remit as a training prison.

Many of the men were extremely frustrated by the lack of progress they were able to make with their long sentences. The offender management unit was understaffed and lacked the consistent and effective leadership that was required to support the men in their care. Sentence plans had often not been completed and the very limited accredited programmes offer was not available to the population of men convicted of sexual offences at all. This meant many were unable to move to category C status or demonstrate that they had reduced

their risk to the public. Public protection arrangements were woeful given the very risky men held at Swaleside. Although not designated as a resettlement prison, the jail was releasing an average of 13 men a month, and although staff were doing their best to support those leaving the jail, communication with outside agencies and probation officers was not good enough.

When the previous, longstanding governor left in February 2024, disastrously HMPPS failed to fill the vacancy and this most risky of prisons had been led by temporarily promoted staff. This damaging hiatus had lasted for more than a year before the current governor took up her post in July 2025.

She had a good understanding of the many challenges facing the prison and staff were positive about her vision, but more operational grip was required in such a fragile establishment. Prisoners and staff complained that they did not see enough of leaders around the jail.

It would not be fair to blame the governor or the many hardworking leaders and officers for some of the findings in this report. Many of the problems, particularly the failure to stem the ingress of drones, an inability to solve chronic recruitment difficulties and large cuts to education provision, are the responsibility of the prison service and the Ministry of Justice.

This report requires a committed response from the leadership team and the prison service to begin to address the deeply concerning failings at the prison. Staff and prisoners should never be expected to work or live in the conditions we found on this inspection.

Charlie Taylor
HM Chief Inspector of Prisons
February 2026

What needs to improve at HMP Swaleside

During this inspection we identified 15 key concerns, of which six 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. **Violence was very high, and many prisoners told us they felt unsafe.** There were insufficient consequences for poor behaviour and not enough was done to incentivise men to behave well.
2. **The supply of illicit drugs was a significant threat to the prison.** Use of illicit substances was very high.
3. **There was no coherent strategy to reduce the consistently high levels of self-harm.**
4. **Time out of cell was wholly insufficient and did not give prisoners sufficient time to complete daily tasks, such as showering and outdoor exercise.** Poor regime reliability impacted on prisoners' attendance at work, education and health care appointments.
5. **Leaders had not tackled prisoners' low and declining attendance at activities, reduced the number of prisoners who were unemployed or raised prisoners' interest and engagement in education, skills and work.** The allocations process was ineffective, and there were insufficient activity spaces for the substantial number of prisoners classified as a high security risk for workplaces.
6. **There were not enough opportunities for prisoners to demonstrate a reduction in risk and progress in their sentence.** Too little structured offending behaviour work took place to challenge and address prisoners' attitudes, thinking and behaviour robustly. There were no accredited interventions for PCoSOs. Category C transfers took too long, and some would be released without the specific interventions they needed.

Key concerns

7. **Early days arrangements were unsafe.** In 2025, six different prisoners had been assaulted or stabbed on their first night.
8. **Levels of use of force were high, and oversight and governance was weak.** Scrutiny of high-level interventions lacked rigour, and nearly half of staff did not have up-to-date training.

9. **There was a lack of order and control.** Staff did not have sufficient confidence in challenging poor behaviour and lacked control on residential units at key times, such as the serving of meals and lock-up.
10. **Leaders had not promoted fair treatment, and the culture did not enable or nurture an inclusive ethos.** The lack of consultation and data interrogation left leaders poorly sighted on the experiences of those prisoners from minority groups.
11. **Clinical oversight of key risks was insufficient.** Wound care did not meet expected guidelines, secondary dispensing was taking place and there was a lack of clinical oversight into cancelled hospital appointments.
12. **Patients who needed transfer to secure hospital under the Mental Health Act continued to wait far too long for a bed.**
13. **There were significant gaps in the prison's management and oversight of public protection arrangements.**
14. **Leaders did not have accurate enough oversight of the quality and breadth of education, skills and work to be able to plan and implement improvements confidently.** Fundamentally, leaders did not offer an ambitious enough curriculum of courses or work opportunities that systematically developed prisoners' knowledge, skills and behaviours to gain employment on release or track the progress prisoners made in their development.
15. **Leaders had not made sure that prisoners who required additional support, including with reading or English for speakers of other languages or those with neurodivergent needs, had their needs met.**

About HMP Swaleside

Task of the prison/establishment

HMP Swaleside is a Category B training establishment

Certified normal accommodation and operational capacity (see Glossary)

Prisoners held at the time of inspection: 879

Baseline certified normal capacity: 1,112

In-use certified normal capacity: 985

Operational capacity: 922

Population of the prison

- About one third of the population are serving indeterminate sentences, including 41 IPPs.
- 40% of prisoners are from black and minority ethnic backgrounds.
- 25% of prisoners are aged 21–29.
- 14% of prisoners are foreign nationals.
- An average of 13 prisoners are released into the community each month.

Prison status (public or private) and key providers

Public

Physical health provider: Oxleas NHS Foundation Trust

Mental health provider: Oxleas NHS Foundation Trust

Substance misuse treatment provider: Change Grow Live (CGL)

Dental health provider: Kent Community Health NHS Foundation Trust

Prison education framework provider: Milton Keynes College

Escort contractor: Serco

Prison group/Department

Long-term and high-security estate

Prison Group Director

Hannah Lane

Brief history

HMP Swaleside opened in 1988 with four wings, A–D. E wing was built in 1998 and F wing in 1999. G wing was added in 2009 and H wing in 2010.

Short description of residential units

A wing – closed

B wing – general population

C wing – general population

D wing – first night centre and induction

E wing – drug recovery unit and incentivised substance-free living unit (ISFL; see Glossary)

F wing – one half is the psychologically informed planned environment (PIPE; see Glossary), and the other half is for general population

G wing – one half is a lifer community, and the other half is for vulnerable prisoners

H wing – unit for prisoners convicted of sexual offences (PCoSOs; see Glossary)

Name of governor and date in post

Abbie Gardner, July 2025

Changes of governor since the last inspection

Lee-Ann Williams, March 2024 to June 2025

Mark Icke, March 2018 to February 2024

Independent Monitoring Board chair

James Morris

Date of last inspection

August 2024 (independent review of progress)

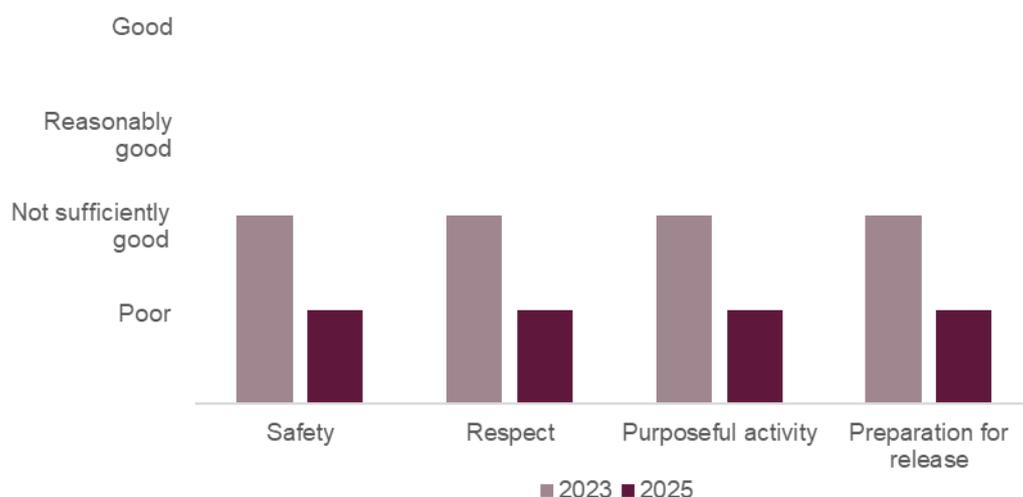
September 2023 (announced inspection)

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 Swaleside, we found that outcomes for prisoners were:
- poor for safety
 - poor for respect
 - poor for purposeful activity
 - poor for preparation for release.
- 1.3 We last inspected Swaleside in 2023. Figure 1 shows how outcomes for prisoners have changed since the last inspection.

Figure 1: HMP Swaleside 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, five of which were priority concerns.
- 1.5 At this inspection we found that none of our concerns been addressed, three had been partially addressed, 10 had not been addressed and one was no longer relevant. 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 no examples of notable positive practice during this inspection, which other prisons may be able to learn from or replicate.

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 Following a protracted period of temporary leadership, a permanent governor had recently been appointed, along with a new deputy. The governor was relatively inexperienced in her role, but her dedication and approach were supported by staff. She had made an honest assessment of the prison's considerable challenges and set immediate priorities to improve safety, security and stability.
- 2.3 There had been a prolonged period of decline across most functions of the prison, and none of the concerns we raised at our last full inspection had been fully addressed.
- 2.4 HM Prison and Probation Service (HMPPS) and local leaders had failed to tackle violence, the overall rate of which had almost doubled since our last inspection and was the highest for assaults against staff of all adult male prisons for the last 12 months. There were insufficient consequences for poor behaviour, and leaders had not done enough to incentivise prisoners to behave well.
- 2.5 HMPPS had failed to solve chronic staffing problems that had hampered the running of the jail. A shortage of operational support grades limited, for example, searching on entering the prison, and there were far too few probation staff to meet the needs of the high-risk population. The prison also struggled to recruit operational middle managers. Although the full quota of officers had been recruited, less than three-quarters were currently available for operational duties, and the prison was reliant on officers sent on detached duty from other jails. Only around half of the officers had more than two years' experience, and the rates of sickness absence and staff attrition were high. Positively, however, the right to work visa for those from overseas, which was more than a third of the officer workforce, had recently been extended up to a further three years.
- 2.6 In response to a national directive, leaders had introduced a restricted regime which they told us was temporary and designed to make the prison safer. However, staff and prisoners were not sufficiently prepared for its implementation, leading to an increase in instability and men in crisis. Leaders had not done enough to keep men safe on arrival at the prison and work to understand and manage potential gang conflicts was inadequate.

- 2.7 The new published regime allowed about half the population only 30 minutes unlocked on most weekdays. This was marginally improved by leaders during our inspection, but it remained wholly insufficient and inhumane.
- 2.8 Leaders had also curtailed access to and time spent in purposeful activity under the new regime. Popular activities that improved employability on release had ceased as a consequence of HMPPS cuts in education delivery.
- 2.9 The capability of the offender management unit (OMU) continued to be affected by longstanding staffing shortfalls and frequent changes in leadership. Prison leaders had also failed to prioritise their public protection responsibilities.
- 2.10 The governor had rightly recognised developing leadership capability as a top priority. She had reorganised her senior team with some new appointments and rotation of roles, and had well-developed plans to address remaining weaknesses through coaching, support and challenge.
- 2.11 Leaders did not have enough operational grip, and we saw evidence of a lack of order and control on residential units. The senior team and managers were not sufficiently visible on wings to support the largely inexperienced group of officers, although development and coaching for custodial managers was now being offered.
- 2.12 Leaders were not using data sufficiently to assess performance and drive improvements. For example, there was insufficient governance and oversight of segregation and of fair treatment. The data that leaders used to manage and monitor education, skills and work provision was incomplete and too often unreliable.
- 2.13 The governor had recognised longstanding cultural problems within the prison and had plans to challenge them. A staff 'climate assessment' was underway and there were plans to seek additional support from HMPPS.

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 In our survey, a quarter of prisoners told us they needed protection from other men on arrival and only 57% said they felt safe on their first night at Swaleside. Both results were worse than comparator prisons.
- 3.2 Early days arrangements were unsafe. In 2025, six different prisoners had been assaulted on their first night, and some had been stabbed during these incidents. The attacks were usually motivated by pre-existing conflicts. Some of the incidents had happened within minutes of the prisoner arriving on the wing, and some were large in scale; one man was targeted by 14 perpetrators.
- 3.3 An induction booklet which considered risk issues was filled out by prison staff and peer workers during a prisoner's early days. However, it was not clear what was done with this information; we found the booklets in a filing cabinet on the induction wing, and some were incomplete. Critically, and very unusually, there was no safety interview recorded in prisoners' electronic case notes during the reception and induction processes, nor any information about risks or gang affiliation. This lack of information sharing undermined efforts to keep prisoners safe.
- 3.4 Over the last 12 months only an average of about nine men had arrived each week, which meant that reception and induction processes were delivered in a bespoke way without any group presentations. Peer workers known as Insiders (see Glossary) were used effectively to give one-to-one advice on both D wing for the main population and H wing for prisoners convicted of sexual offences (PCOSOs). Overall, PCOSOs had the best first night experience, with support from the most experienced Insiders and well-prepared cells.



First night cell on H wing

- 3.5 There were no arrivals for us to observe during our inspection. Reception closed at 5pm daily. We were told by prisoners and staff that arrivals after this cut-off time got a basic service; they were taken directly to their cells with few checks and completed most of their first night processes the next morning, which carried some risks.
- 3.6 In-cell secure laptops (Launchpad) was a huge asset and helped prisoners get most of their information. In their first few days, men were routinely seen by the chaplain and other teams, including programmes and substance misuse services. All new arrivals faced the same poor regime as the rest of the prison which gave them little opportunity to familiarise themselves with prison life (see paragraph 5.1).

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

- 3.7 Swaleside continued to experience very high levels of violence. It had the second highest rate of assaults among adult male prisons in the past 12 months and the highest rate of assaults on staff.

- 3.8 Serious assaults on both staff and prisoners had risen by 78% since the previous inspection, with assaults on staff increasing by 122%. In our survey, 75% of prisoners said they had felt unsafe at some point, and 43% reported feeling unsafe at the time of the inspection. A third of prisoners said they had been physically assaulted by another prisoner, which was worse than similar prisons.
- 3.9 Many prisoners told us they did not feel safe, which affected their daily lives, including their ability to attend purposeful activity or health care appointments (see paragraph 4.54).
- 3.10 Staff, many of whom were inexperienced, were often reluctant to challenge poor behaviour, resulting in a lack of order and control. Prisoners told us that there appeared to be no consequences for misbehaviour, which was compounded by an ineffective adjudication process (see paragraph 3.17). Some prisoners said that behaving badly was the only way to make their voices heard.
- 3.11 Serious assaults were not investigated thoroughly, and lessons were not learned to prevent further incidents. Despite the sharp rise in serious assaults, there were no clear criteria for which cases should be escalated for in-depth investigation. As a result, many inquiries lacked sufficient detail to generate meaningful recommendations.
- 3.12 Leaders told us that gang conflicts were partly responsible for the increase in prisoner-on-prisoner violence, but not enough was being done to manage this. Although the induction peer supporters asked about gang affiliations during the first night checks, this information was not being used to keep prisoners safe (see paragraph 3.3).
- 3.13 There was also little to incentivise positive behaviour. The regime was overly restrictive (see paragraph 5.1), and prisoners viewed it as a form of collective punishment. Although leaders had introduced an additional level to the incentives scheme, 'enhanced plus', this had not provided tangible benefits for those who achieved it.
- 3.14 Swaleside Outreach Service (SOS) continued to be an effective multidisciplinary intervention which supported some prisoners with challenging behaviours (see paragraph 6.35). The SOS team offered a staged approach to engaging prisoners, with the aim of encouraging them to attend off-wing sessions. Although this service provided excellent support, it was insufficient to meet the needs of the population.
- 3.15 At the time of inspection, 22 prisoners were isolating for their own protection. The new regime did not allocate time for these men to be unlocked, although staff told us they tried to do so when possible. Consequently, isolators were not routinely offered showers or outdoor exercise. Oversight and support for this group was inadequate, and little was done to understand their reasons for self-isolation or to help them reintegrate.

- 3.16 We also found examples of violent incidents not being correctly reported or investigated, meaning the true level of violence may have been higher than recorded.

Adjudications

- 3.17 There were insufficient consequences for poor behaviour. The adjudication system was ineffective, and prisoners told us they did not view it as a deterrent.
- 3.18 In the past year, there had been 3,650 adjudications, with 230 still adjourned. This high volume and the delays undermined the effectiveness of the process.
- 3.19 More than 720 adjudications had been referred to the police and 87 remained under investigation. While it was positive that the most serious cases were taken forward, lengthy delays by the police and the Crown Prosecution Service (see Glossary) left staff and prisoners without timely resolution. We were told of a court case for a serious assault against a member of staff that was still pending after several years.
- 3.20 There was no process for rehabilitative adjudications, which was a missed opportunity given the high levels of substance misuse. In addition, there had been no quality assurance or standardisation meetings to review and improve the process.

Use of force

- 3.21 The rate of use of force had increased by 87% since our last inspection and was above the average for similar prisons. During the previous 12 months, 1,035 reported incidents of force had been recorded, 17% of which were planned.
- 3.22 Governance was weak, which was undermined further by insufficient body-worn video camera footage (BWVC). Only 65% of incidents had recorded BWVC footage, much of which was not of sufficient quality.
- 3.23 Until recently there had been no dedicated use of force coordinator. Leaders held a weekly scrutiny meeting, but these lacked multidisciplinary attendance. They reviewed only 25% of incidents and this sometimes lacked challenge. Minutes for these meetings had not been recorded until recently; the new deputy governor had introduced more robust practice and had escalated some incidents accordingly.
- 3.24 In the sample we reviewed, we observed some inappropriate language, poor use of control techniques and inadequate incident management. Only 52% of staff had up-to-date training, which was too low. Prisoners did not receive a post-incident debrief, and we found one example of a prisoner who had not been seen by health care following a restraint, despite prison staff recording that this had been completed. There was also a high number of outstanding use of force statements that had not been completed by officers.

- 3.25 Use of high-level interventions had increased significantly. In the previous 12 months, batons were used on three prisoners and PAVA (see Glossary) had been used on 61 individuals, compared to each only being used once in 12 months before our last inspection. Inquiries into these interventions lacked rigour, although leaders were now addressing this and had recently escalated one incident for investigation.
- 3.26 Leaders could not produce authorisation paperwork for anti-ligature clothing. Use of special unfurnished accommodation had been recorded four times in the previous 12 months; documentation to justify its use lacked sufficient detail, and in one instance there was no record of the mandatory monitoring observations.
- 3.27 The monthly strategic use of force meetings had not taken place for three months and leaders had not explored any emerging themes or disproportionality which we identified as affecting some minority groups.

Segregation

- 3.28 During the inspection, leaders were only able to provide limited data about use of segregation, and we could not be assured that the necessary oversight was in place. Only one meeting had been held in the past year to review segregation governance.
- 3.29 We were concerned that the average length of stay appeared excessive. Several prisoners had been segregated for prolonged periods with no clear exit plans, especially for those who had previously been segregated in other long-term prisons.
- 3.30 Reintegration planning was at an early stage, although the recent appointment of a psychologist to the unit was a positive development. We observed some good management plans, and the psychology team was contributing to improved segregation board reviews.
- 3.31 The regime remained very limited, offering only a daily shower and 30 minutes of exercise. Some prisoners were given basic in-cell work, enabling them to earn a small amount of money, which was positive.
- 3.32 Prisoners spoke positively about staff on the unit, and we observed good interactions. Several prisoners said they preferred segregation because of greater regime consistency compared with the wings and the opportunity to resolve issues. Leaders had responded to the risk of prisoners choosing to remain in segregation by removing televisions and kettles and replacing them with radios and flasks.
- 3.33 We found prisoners segregated on the wings without proper authorisation or safeguards.

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.

- 3.34 Drugs and the illicit economy continued to undermine safety, stability and security. The random mandatory drug testing (MDT) rate was 34% between April and October 2025, but leaders estimated actual use could be closer to 50% because many prisoners refused testing. This had not been addressed through adjudications, although leaders planned to increase sanctions for refusals.
- 3.35 Drones remained the main route for smuggling drugs and weapons. Plans to replace windows and grilles and install anti-drone wire had been agreed, and although no start date had been set, some remedial grille work had begun.
- 3.36 To reduce demand for drugs, an incentivised substance-free living (ISFL) unit and a drug recovery wing had been introduced (see paragraph 4.83). While these provided a slightly better environment than other wings, there were insufficient incentives to encourage prisoners to remain drug-free. This was compounded by a lack of purposeful activity to keep prisoners occupied and enable them to earn money.
- 3.37 We observed poor order and control during our visit (see paragraph 2.11), such as prisoners ignoring staff instructions, including pushing through lines to avoid being searched, and inadequate accounting for prisoners.
- 3.38 Leaders had worked hard to address concerns raised in a recent HMPPS security audit, including strengthening intelligence processes. Safety analysts attended the daily triage meeting, which improved information sharing between departments.
- 3.39 Staff shortages affected the consistent use of enhanced gate security, although leaders had drawn on regional resources to improve searching within the prison.
- 3.40 There was effective inter-agency work to manage risks from organised crime and corruption. The prison held a high number of organised crime group members, which fuelled the illicit economy. Staff corruption remained a serious risk but was being managed appropriately.

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

- 3.41 Leaders had no coherent strategy to reduce the consistently high levels of recorded self-harm which had been gradually trending upwards since the last inspection. We were shown some action plans, but they were not in regular use. The introduction of a very restricted regime, aimed at making the prison safer, had only seen the number of men in crisis rise.
- 3.42 Reasons for self-harm included very little time out of cell, very high levels of violence, easy access to illicit drugs and prisoners' basic needs going unmet. The prison held many men serving long or indeterminate sentences, and they frequently told us that they were unable to progress in their sentences and felt hopeless (see paragraph 6.7).
- 3.43 There were not enough interventions to support prisoners who were struggling. A minority benefitted from living on the PIPE or ISFL units or accessed the SOS (see paragraphs 6.33 and 6.35), but for others there wasn't enough to keep them engaged or distracted.
- 3.44 Most serious acts of self-harm were not investigated to learn lessons or improve care. There had been 158 cell fires in the 12 months to October 2025; an exceptionally high number and the second highest rate in the adult male estate. The damage to cells was all too evident when we inspected some of the residential accommodation. There had not been a full review to understand and address the causes of these incidents, which posed a significant threat to life.
- 3.45 There had been two self-inflicted deaths since the last inspection, and three 'non-natural' deaths, for example, because of drug toxicity. Although the Prisons and Probation Ombudsman (PPO) had raised serious concerns about records of checks on prisoners at risk of suicide being falsified, most planned assurance checks on CCTV footage by managers had not been carried out.
- 3.46 There were between 40 and 50 Assessment, Care in Custody and Teamwork (ACCT; see Glossary) documents open during the inspection, which was a high number to manage effectively. Some men in crisis we spoke to felt cared for, but too many care plans did not capture the key issues that were driving self-harm, which limited their usefulness. Mental health staff were very stretched and were often unable to attend case reviews (see paragraph 4.74).

- 3.47 Arrangements for constant supervision were unsafe. The prison only had two gated cells that allowed for safe, constant observation, but the number of men needing this support at any one time had risen to as many as seven recently. As a result, prisoners were frequently held in a normal cell and watched through their observation panel, which was almost impossible for staff to do effectively. On several occasions during the inspection, we checked on the same prisoner and found different members of staff not looking through his observation panel, sometimes for minutes at a time.



Constant supervision cell

- 3.48 In our survey, only a quarter of prisoners said they could access a Listener, and this service had deteriorated since the last inspection. Problems running the regime and high levels of inexperience among officers, who did not always recognise the importance of the scheme, meant that call outs were too often not facilitated. We also noticed high numbers of cell call bells going unanswered for extended periods during the inspection (see paragraph 4.15).

Protection of adults at risk (see Glossary)

- 3.49 The population contained a high number of complex individuals with significant mental health needs. It was positive to see prisoners with vulnerabilities being discussed at a monthly safeguarding meeting but overall, the prison did not provide a safe environment for the most vulnerable men, and a high number chose to self-isolate (see paragraph 3.15). Staff were not trained to spot the signs of neglect, harm or abuse, and prisoners were often unlocked for such brief periods that it was hard to observe any signs of decline.

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 The prison was a very challenging environment for staff, who were subject to high levels of violence in the course of their duties (see paragraph 3.7). Many told us that they were burnt out and demoralised and expressed frustration at the day-to-day challenges they faced in delivering the daily routine.
- 4.2 In this context, staff lacked confidence in challenging poor behaviour from prisoners and often did not have full control on residential units (see paragraphs 3.10 and 3.37), particularly at key points during the day such as at lock-up and the serving of meals (see paragraph 4.16). We frequently observed infractions, including covered observation panels, vaping on landings and inappropriate dress going unchallenged. We also observed incidents of prisoners being openly disrespectful to staff, which reflected the degree to which staff-prisoner relationships had deteriorated since our last inspection.
- 4.3 Relationships between staff and prisoners were distant, and we were told of some communication and cultural difficulties. While we saw some examples of more positive interactions, particularly on the specialist units, most we observed were transactional and brief. Leaders acknowledged that difficulties maintaining consistent staffing groups on residential units undermined efforts to establish rapport with prisoners.
- 4.4 Prisoners expressed frustration around getting basic needs met by staff, which was compounded by the very limited time they had unlocked to complete domestic tasks or resolve their issues (see paragraph 5.4).
- 4.5 We frequently found middle managers in wing offices, and they were not sufficiently visible on landings to provide support and guidance to staff as they delivered the daily regime.
- 4.6 While we saw some examples of peer workers being used effectively, such as in reception and the employment hub, some prisoner representatives told us that they were not always unlocked to complete their duties. There were no orderlies on wings to assist prisoners in resolving issues or completing forms. A community hub where prisoners could seek advice was staffed by two orderlies, but prisoners'

access to it was very limited as it was only available during their movements to and from work and appointments.



Forms in the community hub

- 4.7 The quality and frequency of key work required improvement. Many sessions we reviewed were cursory or resembled checklists and were not supportive of prisoners' progression. Despite this, prisoners reported more positively on key work in our survey than at similar establishments; 82% of prisoners said they had a key worker (see Glossary), and 59% said their key worker was very/quite helpful, compared to 68% and 39% at similar sites.
- 4.8 Leaders were making good use of data at monthly meetings with custodial managers to identify gaps in key work and drive improvements, and we saw evidence of the safety team sharing the names of prisoners who were vulnerable or who had notable anniversaries approaching so that their sessions could be prioritised.

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

- 4.9 Too many cells were in a poor state of repair. We saw widespread graffiti, fire damage, broken furniture and dilapidated flooring. Cells on F, H and D wing's 3 landing were generally better. The maintenance department worked hard to manage repairs and return out of action cells to use. A 15-week refurbishment programme which involved prisoners had just started. A wing had not been in use for several years, and renovation works had paused while a new contractor was being appointed. Although we were told that refurbishment of B, C and D wings was planned, G wing had received no investment despite the poor environment and leaders' repeated requests.



Cells with missing furniture (top left), graffiti (top right) and fire damage (bottom)

- 4.10 Most showers were dirty, mouldy and poorly maintained, and only 35% of prisoners in our survey said showers were clean. We found smoking paraphernalia and a strong smell of drugs in one of the showers.



Showers

- 4.11 Most wing communal areas were dirty and poorly decorated. Notably, F and H wing were generally cleaner, and had a better range of association equipment. A barber's corner on the incentivised substance-free living unit (ISFL) was a positive addition. The many unused side rooms, cleaning cupboards and sluice rooms were grimy and neglected. Challenges presented by the new regime meant there was less time for wing cleaners to be out working which we were told worsened issues with cleanliness. In our survey, prisoners were more negative than in similar prisons about noise levels on the wing.



Barber's corner (left) and sluice room

- 4.12 Some external areas were littered, particularly near wings without window grilles, and this had exacerbated problems with vermin. There had been some positive work around the memorial garden and the area outside the PIPE unit.



Litter in outside area

- 4.13 During our inspection, the stock of prison-issued kit and clothing was adequate, although leaders' assurance checks showed variable practice in the issuing of this. We also saw some prisoners wearing dirty clothing and sleeping in filthy bedding.
- 4.14 We were told that staffing pressures led to delays in processing requests to retrieve prisoners' property; only 14% of prisoners in our survey said they could get their stored property promptly.
- 4.15 Our survey also found that only 12% of prisoners said cell call bells were answered within five minutes; leaders did not carry out any local assurance checks.

Residential services

- 4.16 Many servery areas and food trolleys were dirty and poorly maintained; on one wing, staff had used cling film in place of the broken Perspex on the servery. Food service was not well supervised; we observed prisoners without appropriate PPE and the improper use of utensils, in particular when used to serve vegetarian, halal, and non-halal food. While a member of staff was standing by the serveries, we still observed unfair portion control; only 19% of prisoners in our survey said they had enough to eat. For most, the evening cold meals were served at cell doors, which was not respectful.



Dirty food trolley (top left), servery area with cling film (top right) and cold dinner food

- 4.17 Prisoners valued the opportunity to cook for themselves, but most self-cook facilities were filthy. Many sinks were blocked, equipment was lacking and some was damaged. Leaders told us many of the cookers had been decommissioned but prisoners continued to use them on some wings and were appreciative of the additional facilities. The self-cook areas were poorly supervised and access to them was inconsistent, with some locked during domestic time and limited further by the new regime.



Blocked sink (left) and broken equipment in self-cook areas

- 4.18 Prisoners could order a range of goods through the prison shop, including some fresh fruit and vegetables for self-catering. During our inspection, delivery processes were not functioning effectively. Prisoners were not asked to sign for their deliveries, which staff acknowledged had the potential to create tension with staff when items were missing. Prisoners were consulted via their secure in-cell laptops on potential additions to the canteen list, which was positive.
- 4.19 Prisoners could order items from catalogues, some of which had been made available on their laptops. However, they were often frustrated that their catalogue orders spent long periods in reception before being cleared for delivery to their wings.

Prisoner consultation, applications and redress

- 4.20 Consultation arrangements with prisoners were weak and had deteriorated since our last visit. The prisoner council had relaunched several months prior to our visit but had been held sporadically since then and there was little evidence that prisoners' issues were being dealt with. Council attendance by staff from different departments of the prison was too limited.
- 4.21 Wing forums were being held on residential units, but these were not fully embedded and some prisoners told us they rarely took place. Leaders acknowledged that more needed to be done to hold these consistently. In our survey, only 45% of prisoners said they were consulted about things like food, canteen or wing issues, compared to 62% at our last inspection. Little use was being made of prisoners' secure laptops to facilitate consultation, though a series of Q&A sessions with local leaders was planned to start imminently.
- 4.22 The prison had received 4,080 complaints in the year prior to our inspection, which was an increase of 11% since our last inspection. The responses we reviewed were generally courteous in tone, though some dismissed prisoners' complaints without sufficient investigation. Around 20% of responses were late.
- 4.23 Complaint boxes on wings often did not have any forms available for prisoners to use. Forms were available in the community hub on the

prison's central concourse, but prisoners access to this was limited (see paragraph 4.6).



Wing complaint box without forms

- 4.24 Quality assurance was being undertaken by senior leaders on 10% of complaint responses, which was providing some good challenge. Complaints against staff were dealt with by their direct line manager before being reviewed by senior leaders, which was not best practice.
- 4.25 Most applications were dealt with digitally, via prisoners' secure laptops or on-wing kiosks. Data was no longer being gathered to assess the timeliness of responses, which was a gap, although previous analysis indicated that most were responded to within five days. Despite this, prisoners expressed frustration at difficulties in having their requests met.
- 4.26 Provision for in-person and video-link legal visits (official prison video conferencing; see Glossary) was sufficient. Leaders had increased the availability of video-link slots held each week, and waiting lists were short. In-person visits were held in private. The library held a good range of up-to-date legal texts for prisoners to reference.



Official visits videolink room

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.

- 4.27 Leaders had not promoted fair treatment; the culture did not enable or nurture an inclusive ethos. Staff and prisoners reported tensions and cultural differences that had not been sufficiently addressed.
- 4.28 There had been hardly any consultation with minority groups, which left leaders poorly sighted on their experiences. This was compounded further by a lack of data analysis to identify and address any disproportionality. Unusually, data on potential disparities was not discussed at other forums, such as in relation to complaints or areas of safety, as we would usually see. Young adults were the only exception where a programme of work across the long-term and high-security estate analysed some data in relation to this cohort.
- 4.29 Staffing gaps had led to a lapse in oversight; there had been no equality meetings for over four months, and leaders and managers were poorly sighted on previous work. While there was a lack of strategic direction to address concerns in this area, a new manager

had been appointed, a staff 'climate assessment' was ongoing and there were plans to seek additional support from HMPPS.

- 4.30 Prisoners from several minority groups reported to us they felt unfairly treated, for example in relation to their race. In our survey, Muslims and minority ethnic prisoners were more negative about having a member of staff they could turn to if they had a problem.
- 4.31 Prisoners with physical disabilities reported frequent challenges with the broken lifts and their ability to get around the prison. Given the high number of cell fires at the prison (see paragraph 3.44), it was concerning that some personal emergency evacuation plans were not sufficiently detailed or easily available to staff.
- 4.32 We were not assured that staff understood the needs of transgender prisoners; we observed repeated misgendering and uncertainty about basic arrangements, such as showering.
- 4.33 Under the new regime, retired and long-term sick prisoners were not routinely unlocked during the day and there was no tailored provision for older prisoners.
- 4.34 Around 14% of the population were foreign nationals and there was a foreign national specialist in post. However, outside of immigration related issues, there was no broader work to understand or support this group. Eligible prisoners had to apply for complimentary PIN credit rather than receiving it automatically. There were eight prisoners who had been identified as not being proficient in English, but professional interpreting services were rarely used.
- 4.35 More positively, an outside organisation met regularly with a group of armed forces veterans, and on the PIPE unit leaders held monthly multicultural meetings.
- 4.36 There had been some focus on young adults, with joint work involving psychology, offender managers and a prison lead. There was a recognition that they experienced worse outcomes in significant areas, for example, leaders had identified that 70% of young adults were unemployed. However, attendance by young adults at the monthly meetings was low, and this joint work had yet to drive tangible improvements.
- 4.37 Discrimination incident reporting forms (DIRFs; see Glossary) were not freely available, and boxes were not routinely checked for submissions, which was poor. In the sample we reviewed, some prisoners waited months for a response, and the quality of investigations was generally inadequate. There was no internal or external quality assurance in place.

Faith and religion

- 4.38 Despite their efforts, staffing challenges in the chaplaincy team restricted their ability to provide pastoral support. For example, there had not been a full-time Imam, despite Muslims being almost a third of

the population. The team carried out all its statutory duties, with the exception of meeting all of those due for release. Facilities were pleasant, including a dedicated Mosque and Chapel which were also used by other faith groups, alongside a smaller multi-faith room.



The chapel

- 4.39 Faith-based classes were delivered alongside corporate worship. However, staff and prisoners told us punctuality at corporate worship was a persistent issue and reduced service time. Services were rarely cancelled, although during our inspection, the Friday service for Muslim prisoners had been cancelled due to delays in the regime and staffing issues.

Health, well-being and social care

Expected outcomes: Patients are cared for by services that assess and meet their health, social care and substance misuse 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.

- 4.40 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 there were breaches of relevant regulations and issued a request for an action plan following the inspection (see Appendix III).

Strategy, clinical governance and partnerships

- 4.41 Oxleas NHS Foundation Trust continued to be the prime provider of health services with Change Grow Live (CGL) delivering psychosocial substance misuse service support. Kent Community Health NHS Foundation Trust delivered the dental contract. The health needs analysis was currently being reviewed.
- 4.42 While partnership working across providers was a strength, there were weaknesses in partnership working with the prison. Not enough had been done to improve the high non-attendance rates at health appointments, which was a concern at the last inspection (see paragraph 5.6).
- 4.43 Overall, clinical governance and oversight of the service had improved since the last inspection but was still lacking in some key areas. Leaders were not sighted on poor wound care and secondary dispensing of medicines in segregation. Too many external hospital appointments were cancelled due to a lack of escorts. Services were delivered by a skilled, experienced and resilient workforce often in the face of multiple competing demands, such as emergency response and medicines administration. It was concerning that violence and aggression towards health care staff was increasing.
- 4.44 Leaders participated in a range of clinical governance meetings, both locally and regionally, which were focused on patient safety and service improvement. Clinical incidents were reviewed promptly and most lessons learned were disseminated among staff. The management of health care complaints was coordinated effectively, and responses we sampled were good.
- 4.45 Long-standing difficulties in recruiting staff, particularly in primary care and mental health, persisted, however the provider covered shortfalls with regular agency staff.
- 4.46 Mandatory training compliance was good, and clinical and management supervision arrangements were embedded. Most staff we spoke to felt supported. Annual appraisals were undertaken, and safeguarding arrangements were robust. Leaders and staff we spoke to understood their safeguarding responsibilities, with a senior nurse providing good oversight.
- 4.47 Patient engagement had been improved with services now facilitating regular forums on the wings, although there were limited opportunities for prisoners to adopt peer support roles.
- 4.48 Health staff used SystmOne, the electronic clinical record, and most notes we accessed were clear, concise and free from medical jargon. Staff we spoke to understood their responsibilities relating to information governance.
- 4.49 Clinical rooms were clean and largely met infection prevention standards.

- 4.50 Emergency medical equipment contained the necessary kit and was subject to regular checking. Health staff and control room staff told us there were no delays in ambulances entering and exiting the prison.

Promoting health and well-being

- 4.51 The provider had a health promotion plan in place, and a diary of events was being delivered, including a calendar based on national promotion programmes. However, more work was needed to ensure health promotion was a whole prison approach and not just the focus of health care services.
- 4.52 Screening programmes and NHS health checks were offered to patients. Vaccinations were offered to all patients; however, the uptake was low. The provider had plans in place to address the issue.
- 4.53 Sexual health services were available to patients provided by specialists who regularly attended.

Primary care and inpatient services

- 4.54 Patients requiring primary care services generally received good levels of care. However, some patients with wounds did not always receive the appropriate care and this had led to worsening health outcomes. Patients told us they were happy with the care they received and spoke highly of the staff. However, they complained about the challenges in getting to health care appointments due to safety fears and the prison regime.
- 4.55 All new arrivals to the prison were screened by nursing staff to address any immediate care needs and plan future care. Where patients had ongoing physical health needs, the relevant appointments were made with appropriate health professionals.
- 4.56 Patients had access to health care professionals, including nurses and GPs, through the prison application system. In addition, a wide range of allied health professionals were available to patients, including physiotherapists, podiatrists and opticians. Waiting times for clinicians were reasonable.
- 4.57 Despite this, far too much clinical time was wasted. In the month of November 2025, 46% of appointments did not take place. In addition, too many external hospital appointments did not take place due to a shortage of prison staffing to escort them, which was unacceptable.
- 4.58 Patients with long term conditions received high quality care. A highly skilled and diligent senior nurse ensured relevant, person centred, and holistic care plans were in place.
- 4.59 End of life care was delivered to a high standard. We saw several examples of compassionate, needs led and bespoke care. Staff knew their patients well and had a good understanding of their needs.

- 4.60 Emergency medical care was good. Two paramedics worked in the team and responded to all emergency calls when on duty. Care records demonstrated high quality of care; however, some improvements were needed in the recording of physical observations (NEWS2; see Glossary).
- 4.61 Discharge planning was thorough. A dedicated team identified patients nearing release and planned for continuity of care. Patients had the opportunity to meet with staff specifically to discuss their release plans. In addition, patients were provided with literature bespoke to their care needs and local area, which was good.
- 4.62 The inpatient unit continued to be a valuable resource for patients, with leaders ensuring admissions and discharges were clinically indicated. Patients we spoke to were very complimentary of their care and treatment, and it was positive to observe therapeutic activity taking place alongside clinical care. There was a strong focus on multi-disciplinary oversight and care planning of patients on the unit.

Social care

- 4.63 A memorandum of understanding between the prison and Kent County Council (KCC) enabled good partnership working in providing social care, which was delivered by a domiciliary care agency (Blossoms). There was effective joint oversight and management of the care process.
- 4.64 There had been an increase in referrals to KCC for a social care assessment (33 in the previous six months versus 23 at the last inspection). Patients were assessed promptly by an experienced occupational therapist and social worker who regularly visited the prison.
- 4.65 Five patients were in receipt of a social care package (see Glossary) and had care plans in place, and patients we spoke to were complimentary about the care they received. During the inspection, care staff had reported being unable to access some patients for their prescribed care due to the recent implementation of a restricted regime.
- 4.66 The KCC occupational therapist coordinated the supply of any aids or adaptations that were required and access to these had improved since the last inspection.
- 4.67 Concerningly, as at the last inspection, social care peer workers continued to receive no oversight, training or supervision from the prison which carried considerable risks.

Mental health

- 4.68 The integrated mental health team was working hard to meet the rise in mental health need at the prison. In our survey, 70% of respondents said they had a mental health problem, and referrals to the team had trebled in the last six months.

- 4.69 Access to support from the team was significantly hampered by the prison regime and a lack of safe and confidential space to undertake therapy with patients.
- 4.70 Despite this, referrals were managed promptly and efficiently using a bespoke, joint-decision-making model to ensure patients were managed on the most appropriate pathway.
- 4.71 Patients continued to face long waits for some psychological therapies, however clinicians now had good oversight of those waiting and prioritised those with greatest need. It was positive that psychology staff now facilitated valuable groupwork, which was well received and valued by patients.
- 4.72 The team was well-led and consisted of a rich mix of skilled and experienced disciplines who worked well together.
- 4.73 Patients had prompt access to a psychiatrist; however, they reported regular difficulties in accessing patients due to poor attendance at clinics. Patients with severe and enduring mental health problems had access to annual physical health checks in line with national guidelines. The team ensured continued care coordination of patients under Section 117 of the Mental Health Act aftercare arrangements.
- 4.74 The team attended all initial ACCT reviews but were often unable to attend case reviews. Staff maintained a regular presence in the segregation unit and inpatient department. Joint working with substance misuse services and PIPE colleagues was very good and overseen by the weekly multi-disciplinary team meeting.
- 4.75 Records we looked at met professional standards, but not all patients had a care plan. Leaders were sighted on this and addressing it.
- 4.76 Staff and leaders told us they felt unsafe in their office which was based on C Wing across from the wing's medicines administration hatch.
- 4.77 Acutely unwell patients continued to wait far too long for transfer to hospital under the Mental Health Act. In the 12 months prior to inspection, 21 patients had been transferred with only five being transferred within 28 days due to the lack of secure beds. One patient waited an unprecedented 711 days, an unacceptable failure. We remained gravely concerned that patients continued to experience wholly avoidable harm while waiting, and that outcomes were being compromised because patients were not receiving the timely, specialist care and treatment they required.

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

- 4.78 The substance misuse services were impressive and supported the drugs strategy aims of reducing demand and providing recovery opportunities for men.

- 4.79 CGL supplied psychosocial support to around 38% (334) of the population, a very large number. Recovery workers were well led, supervised and trained. Funding for more staff had been secured, which reflected the demands on the service, heightened by around 50 men thought to be under the influence (UTI) of intoxicants each month. All new prisoners were offered harm minimisation guidance, an assessment, or could subsequently self-refer for support.
- 4.80 Following need and risk assessments CGL offered clients pertinent one-to-one and group therapies, several of which were innovative. Alongside conventional support using personal workbooks and education on issues such as spice and hooch, there was SMART (self-management and recovery training), foundations of change and building bridges programmes, and yoga/soundbox relaxation and ice bath therapy, which expanded self-awareness.
- 4.81 Clients on the drug recovery wing were well supported with group programmes and communal activities. Clients we spoke with could articulate benefits from the work, but experienced challenges in gaining access to therapy or missed therapy due to the regime, which led to frustration and boredom.
- 4.82 CGL responded promptly to clusters of UTIs on the wings with awareness 'pod' groups and advice for those affected.
- 4.83 Clients achieving abstinence could graduate to the ISFL (see paragraph 3.36) to support substance-free living.
- 4.84 CGL contributed as appropriate to prison safety meetings including ACCT reviews, complex case meetings and adjudications. They had provided around 100 staff with relevant local information on addictions at open events.
- 4.85 CGL co-facilitated joint clinical reviews and depot clinics with Oxleas, with whom they shared the SystmOne clinical record. Care was compassionate, truly integrated and recovery plans were updated at each clinic. Joint clinical records were very good and recorded patient choices.
- 4.86 Oxleas provided opiate substitute therapy (OST) for 26 patients, but few (six) were prescribed buprenorphine by depot injection, the OST of choice in a training prison. Work was underway to identify more patients who could benefit. Alcohol detoxification treatment was available but rarely required.
- 4.87 CGL supervised four peer workers and two volunteers who supported others in recovery and facilitated mutual aid groups. Valued fellowships such as AA, CA (Cocaine Anonymous) and UKNA (Narcotics Anonymous in the UK) regularly visited the prison, and plans were in place to introduce GA (Gamblers Anonymous), which would be a major achievement.

- 4.88 Families were encouraged to be involved in the recovery of their men at the prison. Recovery workers with visiting Connecting Communities agents jointly ensured that clients being released had practical support to engage with community addictions services, housing and probation to minimise risks at a vulnerable time. Support included harm minimisation advice and supplies of Nyxoid (naloxone – used to reverse the effects of opiate overdose).

Medicines optimisation and pharmacy services

- 4.89 Dispensing of medicines was off-site. A pharmacist attended the prison weekly; he and the lead technician provided effective oversight of the service. Swaleside contributed to Kent prisons' medicines management meetings, and appropriate signed standard operating procedures were located in the health centre. Medicines use reviews were completed by the pharmacist, who also ran regular pharmacy clinics for patients.
- 4.90 Patients' dispensed medicines were transported efficiently to Swaleside. Following a recent review, a new cold storage container had been ordered to improve the supply chain. Transportation of medicines to wing administration rooms, including controlled drugs, was secure.
- 4.91 Medicines administration rooms were of mixed design and utility; some required ergonomic enhancements, though were generally adequate. Stock was lean, in date, safely stored and monitored. Secure dispensing cabinets for patient use had not been utilised despite being on-site for several years, which was disappointing.
- 4.92 Following risk assessment, around two-thirds of patients received their medicines in-possession, which was good. However, we saw no signed copies of the risk assessments. The lead technician had identified and raised this omission for action. Other patients were administered their named medications twice per day and could access homely remedies or common preparations via patient group directions from stock.
- 4.93 While the availability of medicines was good, patients frequently told us they could not gain access to medicines hatches at the prescribed times due to lack of officers or limited time out of cell. This affected the therapeutic effectiveness of some medicines due to omitted doses.
- 4.94 Officers were present to regulate the queues at medicines hatches on a minority of wings, which introduced unnecessary risks of bullying and diversion on most wings. Also, in several queues, confidentiality was compromised as patients were allowed to crowd around the hatches. Medications were not always administered safely in the segregation unit. Staff explained to us customary practice prior to our inspection was medicines for administration were prepared then taken to segregation, which was unsafe.
- 4.95 The pharmacist effectively disposed of waste medicines (including de-natured CDs).

Dental services and oral health

- 4.96 Kent Community Health NHS Foundation Trust provided a full range of community-equivalent dental treatments.
- 4.97 Patients wishing to see the dentist submitted an application, which was quickly reviewed by the team. Triage appointments were booked with a nurse before a dental appointment was booked, if required. Waiting times were good.
- 4.98 Too much clinical time was underutilised as patients were not always able to get to their dental appointment. Where appointments were missed, patients were rebooked in the next available slot. Emergency appointments were available for patients in pain within 24 hours.
- 4.99 Dental staff were highly skilled and demonstrated good knowledge of the patients in their care. Care records were up to date, and the dental suite was in good condition with appropriate equipment in place and well maintained.

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 In response to a long-term high-security estate directive, a more restricted daily regime was introduced on the first day of our inspection which aimed to improve safety and stability. The new regime severely curtailed prisoners' time out of cell, and its rapid implementation had given staff and prisoners insufficient preparation for the changes, creating significant confusion and frustration among staff and prisoners. We were told that the new regime was a temporary measure that would be reviewed in three months.
- 5.2 Around 44% of prisoners were not in purposeful activity, which was far too high for a training prison. Under the new regime these individuals would only receive 30 minutes of time out of their cells on most weekdays, which was inhumane. During our inspection this was increased to an hour and a quarter to facilitate showers but was still insufficient, and we observed inconsistencies in how the regime was being delivered between residential units. The regime on the psychologically informed planned environment (PIPE) unit was the exception to this, where prisoners were still unlocked for most of the day.
- 5.3 Time out of cell at weekends was also poor, at a little over an hour for all prisoners who were not in essential work roles (such as those employed in the kitchens).
- 5.4 Prisoners expressed frustration that the new regime did not give them enough time unlocked to access outdoor exercise, associate with their peers and complete other domestic tasks. This impacted on full-time workers, who told us they did not have time to shower or spend time outdoors after returning from work.
- 5.5 Around a quarter of prisoners were in full-time work, and depending on their role, they could expect to get around four to six hours unlocked each day. Prisoners in part-time work could expect around three to four hours out of their cells.
- 5.6 Regime reliability was poor, and prisoner movements were often delayed, which impacted on their time at work, education and appointments. These issues pre-dated the implementation of the new

regime; local records showed that, in the three months prior to our visit, roll checks and movements were frequently late. Staff in different functions told us that this had impacted on prisoners' attendance (see paragraphs 5.27, 4.39 and 4.42).

- 5.7 Although there was some recreational equipment available on wings, disappointingly there now was little structured enrichment activity taking place outside of the specialist units.



Wing landing

- 5.8 The gymnasium was a reasonably well equipped and staffed facility, with an attached sports hall. As reported at previous inspections, the showers were in very poor condition, lacked privacy and continued to suffer from issues with water pressure.



The gym (left) and water damage in the gym changing room

- 5.9 In line with the new regime, the gym was running a restricted timetable that offered just 14 sessions per week, including weekends. This was supplemented by some team activities such as volleyball, powerlifting, and Park Run. Football sessions were held weekly on the outdoor pitch, but we were told that these were rarely well attended.



Football pitch

- 5.10 Attendance at the gym was poor. Local records showed that only 36% of the population were using it, and daily attendance was usually significantly below capacity. We were told that this was partly the result of prisoners' perceptions of safety, which was reflected in a survey of the population conducted by gym staff. In order to provide access to all prisoners in the restricted timetable, sessions were mixed between wings.
- 5.11 No accredited qualifications were being delivered by the gym, though there were advanced plans to begin delivering these.
- 5.12 The library was a relaxed environment with a good stock of books, magazines and DVDs, but access was poor for those not engaged in education. The library timetable only offered capacity for 90 prisoners to attend from the wings each week, and it was not open in the evenings or at weekends.



The library

- 5.13 Attendance at the library was low. Data from the previous six months showed that 40% of sessions had been cancelled, often due to staff shortages, although leaders had begun to address this by removing the requirement for the library to have a dedicated officer.
- 5.14 Prisoners who were able to access the library could take part in activities such as puzzles and crafts, but there were no group activities taking place besides a book group which had recently had its first meeting on one of the residential units.
- 5.15 In the absence of reliable access to the library, a popular delivery service was operating on wings. Data showed that more than 500 deliveries were made to prisoners each month.



Wing library return box

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.

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

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Inadequate

Personal development: Requires improvement

Leadership and management: Inadequate

5.17 Leaders had not corrected most of the key weaknesses in education, skills and work (ESW) identified at the previous two full inspections. They had not addressed prisoners' low and declining attendance at ESW activities. They had not reduced the number of prisoners who were unemployed or raised prisoners' interest and participation in ESW. Around half of all prisoners were not involved in purposeful activity and elected to remain on their accommodation wings during the working day.

5.18 Leaders believed there were more than sufficient full and part-time activity spaces for the prison population, but even so they were under-allocating prisoners to those spaces. Leaders did not know exactly how many spaces there were or whether they always related to viable activities. Too many of the spaces were for menial wing-related work, and most prisoners allocated to these activities spent very little time or energy on them during the working day. Leaders' recent introduction of a safety regime had worsened the attendance and punctuality of prisoners who wanted to attend ESW by preventing or delaying their

arrival at sessions. This significantly reduced the time prisoners could spend on their activities. For example, prisoners assigned to the gardens work party had only 15 minutes of activity rather than the planned two hours outside. Prisoners in the industry workshops were too often unable to complete their tasks due to a lack of time.

- 5.19 Leaders had not ensured that the curriculums in education and industries met prisoners' needs and developed their personal, academic or professional skills. The curriculum offer was too narrow and lacked ambition. Leaders had reduced the offer in education to focus mainly on a core of English and mathematics. Leaders had discontinued vocational courses which supported prisoners' employability, such as multi-skills in construction, warehousing and catering. Peer mentoring spaces had been reduced by half. Neurodivergent prisoners, who accounted for approximately three-quarters of the prison population, were not benefitting from any prison-wide support strategies. Senior leaders were not using the regular briefings from the prison's neurodiversity support manager to support prisoners' engagement in ESW.
- 5.20 Leaders had not ensured that prisoners who attended work followed a structured curriculum or that managers had a consistent and effective way to promote and record prisoners' learning. Consequently, prisoners did not build their knowledge and employability skills in these areas well enough. Instructors' assessment practice was weak in some areas of work and industries, and there was no clear link between prisoners' sentence plans and their progress between successive levels of learning.
- 5.21 During the inspection, inspectors identified that much of the data leaders used to manage and monitor the performance of the ESW provision was incomplete and too often unreliable. This severely compromised leaders' ability to plan and implement improvements with confidence, identify all areas of strength and weaknesses, or recognise trends. For example, leaders and managers did not have comprehensive data on achievement rates or the progress prisoners made on non-accredited qualifications. Leaders had collected data showing a large number of prisoners whose first language was not English. However, this data included prisoners who were foreign nationals but who were already competent English speakers. Managers did not have data to show how many prisoners progressed into work through working in prison industries, nor did they plan for or record consistently well the new employment skills prisoners gained through working in those industries. Leaders' plans to improve data collection and analysis were in their infancy.
- 5.22 Managers had continued to provide effective information, advice and guidance (IAG) during prisoners' induction to ESW. Prisoners were given accurate information on the education, skills and work provision and the importance of English and mathematics in life and work. IAG managers set prisoners specific targets for progress, which managers subsequently monitored.

- 5.23 Leaders recognised that the allocations process was ineffective, but their improvement actions had not had the full impact intended. Allocations staff did not always know which prisoner was allowed to do what activity, or who they could work or learn alongside. There were insufficient activity spaces to allocate the substantial number of prisoners classified as a high security risk for workplaces. Too few prisoners, particularly those with English as an additional language, could access the education they needed due to lack of places. As a result, they were not developing the English reading, writing and listening skills they needed to succeed. Ultimately, allocations staff focused too much on dealing with prisoners who were already allocated to an activity and wished to progress to another, and too little time on getting the long-term and unemployed and disengaged into ESW. During the inspection, managers implemented a concerted effort to reduce the substantial waiting list for activities allocations. While this had some positive impact, the prisoners newly approved for an activity still had to wait for a space to become available and the waiting list was not eliminated. While leaders had implemented preferential pay rates for attending education designed to incentivise prisoners' participation, prisoners were still not taking part.
- 5.24 The education provider, Milton Keynes College, offered education courses that were structured logically and the college's qualified teachers had appropriate subject expertise. While teachers planned lessons carefully, the time available for them to teach was reduced heavily by the new regime. Even so, teachers used a range of teaching techniques well. They mostly provided appropriate support in their lessons for prisoners identified with additional learning needs. For example, they understood the needs of prisoners who had bi-polar disorder and were vigilant about maintaining their emotional well-being. Most prisoners on education courses learned new knowledge and skills which were appropriate to the level of their course. Most of the small number of prisoners who stayed to the end of their courses achieved their qualifications.
- 5.25 Education staff supported prisoners on higher level and distance learning programmes appropriately to make timely progress. These prisoners worked independently using secure, offline laptops for in-cell working. Other prisoners could also use secure laptops for research purposes. The Virtual Campus was now rarely used.
- 5.26 Leaders had not implemented the prison's reading strategy in full, and what was in place was piecemeal. Leaders were only at the early stages of developing a sustained and systematic programme promoting prisoners' reading skills. No staff had been trained in phonics. Recently appointed Shannon Trust (see Glossary) staff had selected and briefed a small number of reading mentors to work directly with prisoners with low or no reading skills and were in the process of appointing more. However, leaders had not ensured that Trust staff had a contract that was long enough for them to support more than a small proportion of the prisoners who needed help to start reading.

- 5.27 Prisoners' attendance in education was too low and declining. On average, only around half of those allocated to a session attended it. Too many prisoners who chose to attend education arrived late, which inhibited their learning and distracted those who had already arrived. Prisoners' attendance at industry workshops was also too low. For example, too few attended either the DHL workshop or waste management, which jeopardised meeting contractual targets.
- 5.28 Overall, too few prisoners regarded ESW as a viable and productive alternative to remaining on their wings. However, the minority of prisoners who chose to participate in education and industries off the wings mostly engaged with these activities and behaved well. Prisoners treated staff and peers with respect in education classes and industry workshops. They responded well to the supportive atmosphere teachers and instructors created. Prisoners in industries used protective equipment appropriately. Incidents of violence in education and industries off the wings were infrequent and substantially lower in number than in the rest of the prison. Prisoners felt safe and well supported in ESW off the wings. They knew how to seek support if they needed it.
- 5.29 Leaders and managers did not equip prisoners with the necessary skills to prepare them for further study and work or to secure employment on release. For example, wing cleaners were mostly under-occupied and unsupervised in their work and did not develop their skills in any meaningful way. Instructors and wing staff did not routinely check the quality of cleaners' work on the wings. Consequently, the lack of cleanliness in parts of some wings was insanitary and a danger to health. Many of the recently appointed instructors were yet to receive relevant training in their specialist area of work. Managers and instructors did not monitor or record prisoners' progress in personal and professional development consistently well.
- 5.30 Leaders had commissioned a few innovative opportunities to develop prisoners' wider skills. These included monthly events exploring the spoken and written word, and sessions on philosophy. These were popular but with space for only a small number of prisoners. Prisoners had insufficient opportunities for meaningful encounters with employers.
- 5.31 Prisoners in ESW mostly made a positive contribution to prison life, taking pride in their work and showing resilience. Teachers and instructors had taught prisoners a reasonable understanding of life in modern Britain and how to keep themselves safe from radicalisation. In classrooms and workshops, diverse groups of prisoners learned to work collaboratively.
- 5.32 ESW staff knew the prison population well and demonstrably cared about prisoners' skills development, well-being and progress. They made themselves accessible to most prisoners and provided incidental support for any experiencing difficulties. However, this approach was far from typical of the wider culture of the prison.

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 Many prisoners were far from home serving long sentences, and their families faced long journeys and high costs to visit them. Only about 40% of men came from Kent or London; we spoke to visitors from areas as far away as Liverpool, Newcastle and Devon. One woman told us that her return journey from Oxford on public transport, including a taxi, had cost £120. The prison did not provide any transport from the station on visit days.
- 6.2 Nonetheless, social visits were delivered well and visitors we spoke to were positive about their experience. They especially valued the visitors centre staff and the unusually good café in the visits hall. There was a good range of family days run by the Prison Advice and Care Trust (PACT; see Glossary), as well as some organised by the psychologically informed planned environment (PIPE) and incentivised substance-free living (ISFL) units.



Visits hall

- 6.3 About half the population had not had a social visit in the previous six months. In many cases, relationships had lapsed during long sentences. In this context, we were surprised that only 18 men were currently being supported by the PACT family engagement worker and only four prisoners were accessing the chaplaincy's official prison visitor scheme. The family engagement worker reflected that many prisoners felt hopeless and did not see the point of troubling their families. There were no regular events in the visits hall to bring together the most socially isolated men, as we sometimes see in other prisons.
- 6.4 It was good to see after school secure social video calls running in the week, but too many booked video sessions did not go ahead or started very late because staff did not bring prisoners promptly to the centrally located suite. In-cell secure laptops were a real asset and made using the email-a-prisoner scheme easy.
- 6.5 Aside from the well-regarded PACT team, which faced a period of transition as several staff had resigned, there was too little other provision to help men rebuild their family ties. For example, only two parenting courses had taken place and hardly any prisoners had made a Storybook Dads recording (see Glossary) in the last six months.

Reducing reoffending

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

- 6.6 The establishment held a predominantly high-risk and long-term population of prisoners mostly convicted of serious and often violent crimes.
- 6.7 Swaleside was not achieving its purpose as a category B training prison. Many prisoners we spoke to expressed considerable frustration

over their lack of progression, described feeling stuck and having given up hope. Too many others were merely resigned to 'passing time' and serving their sentence without any interventions or constructive challenge. In our survey, only 39% of prisoners said their experience was less likely to make them offend in the future.

- 6.8 Work to reduce reoffending was not well coordinated. Partnership meetings were not held consistently. The strategy was underdeveloped, not fully reflective of the up-to-date needs of the population and lacked clear target dates to drive improvement.
- 6.9 The offender management unit (OMU) continued to be affected by longstanding staffing shortfalls and frequent changes in leadership, impacting on the unit's morale, stability and capability to carry out some of its core functions.
- 6.10 The unit should have had 15.5 probation prison offender managers (POMs), but only five were actively in post and working in the prison. Workaround measures had been implemented to mitigate this deficit, such as employing three remote-working agency probation officers. However, this did not replace the need for a full complement of on-site permanent probation officers to manage and motivate such as challenging and high-risk population.
- 6.11 The longstanding shortage of probation POMs meant caseloads were too high to be manageable. POMs and case administrators told us they were overwhelmed. Not all felt there was effective oversight of the volume and quality of their work, or enough focus on their professional development. They also stated that OMU leaders were not sufficiently approachable or visible.
- 6.12 Contact with prisoners was largely infrequent, predominantly reactive to timebound tasks and did not drive prisoners' motivation and sentence progression sufficiently. In one case, we found a prisoner who had not had any recorded POM contact for over 14 months. The delivery of key work was inconsistent and did not support offender management.
- 6.13 Too many prisoners did not have an up-to-date offender assessment system (OASys; see Glossary) assessment even within HMPPS timescales (where the expectation is to undertake review every two to three years or when there is a significant change in circumstance), which hindered their ability to progress. Most prisoners we spoke to were not aware of their plans and had not been involved in their design.
- 6.14 In our survey, only 28% of respondents who had a sentence plan and knew what their targets were said that someone was helping them to achieve them.
- 6.15 Categorisation reviews considered an appropriate range of information, including contributions from the prisoner, but they were not always timely. The use of administrative staff to approve some recommendations was inappropriate. Little work took place to inform those who were unsuccessful in being downgraded to a lower security

category of what they needed to do to improve their chances of a positive outcome at a future review.

- 6.16 During the previous 12 months, 96 prisoners had had their categorisation changed from B to C, and a very small number had been categorised as suitable for open conditions. However, category C prisoners waited far too long to transfer, particularly those convicted of sexual offences. At the time of the inspection, about 100 category C prisoners were waiting to move, the longest of whom had been waiting over four years.
- 6.17 There were sometimes delays in prisoners being released beyond their home detention curfew (HDC; see Glossary) earliest eligibility date. The reasons for this included a lack of accommodation in the community and delays in community offender managers (COMs) verifying the suitability of the proposed address.
- 6.18 About a third of the population were serving indeterminate sentences, including 41 for public protection (IPP; see Glossary), all of whom were beyond the tariff set when they were sentenced. There were no forums to engage with this population, and many prisoners relied on peers for information about their sentence. The OMU and psychology department had recently introduced monthly meetings to assess individual IPP prisoners' needs, review opportunities for progression and trouble-shoot complex cases, which was positive.
- 6.19 In the last 12 months, 106 parole boards had been held, resulting in 19 prisoners being directed for release and one IPP prisoner granted open conditions. Psychology staff contributed appropriately to reports and hearings.

Public protection

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

- 6.20 Most prisoners were assessed as presenting a high risk of serious harm to others and were eligible to be managed on release under Multi-Agency Public Protection Arrangements (MAPPA; see Glossary) because of the serious nature of their offences.
- 6.21 There were considerable gaps in the prison's management and oversight of public protection arrangements. There were backlogs in the screening of new arrivals and weaknesses in the identification of potential risks and application of restrictions.
- 6.22 Monitoring arrangements, including controls on contact through written correspondence and telephone communication were not consistently applied when they needed to be. There were delays in prisoners' calls being listened to. Authorisations and reviews were not always timely, and decisions were not always adequately informed.

- 6.23 A public protection steering group, designed to provide senior manager governance and steer of multi-agency risk management arrangements, had only recently been reinstated following a gap of over a year.
- 6.24 The inter-departmental risk management meeting was poorly attended and did not have sufficient oversight of all high-risk prisoners. In some cases, we saw examples of effective communication between individual POMs and COMs in preparation for prisoners' release, including three-way meetings involving the prisoner, but this was not consistent practice. There was little evidence of clear escalation processes to follow up on the lack of responses from COMs. MAPPA levels were not always confirmed in good time prior to release.
- 6.25 The prison's written contributions to MAPPA panels contained relevant information but were often not sufficiently analytical.

Interventions and support

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

- 6.26 The well-led programmes team had recently introduced the new suite of HMPPS offending behaviour programmes (OBPs), Building Choices (see Glossary).
- 6.27 Although the prison lacked a wider, up-to-date needs analysis for reducing reoffending, managers had developed a clear profile of the treatment needs of most of the population. This included a detailed understanding of prisoners' risk levels, likelihood of reoffending, level of motivation, offence type, sentence length and suitability for treatment.
- 6.28 The programmes team was prioritising waiting lists and the allocation of prisoners onto OBPs in line with national instructions, such as giving preference to those due for parole or nearing the end of their sentence. However, this limited the opportunity for many others to demonstrate progression, such as prisoners with longer than 12–18 months left to serve.
- 6.29 Only a small number of prisoners (about 25) had completed an OBP since April 2025. The prison did not offer any accredited interventions for prisoners convicted of sexual offences, which was a significant gap, and very few had transferred to undertake one elsewhere. Some prisoners would be released before they had the opportunity to complete a programme and demonstrate a reduction in their risk, which was poor.
- 6.30 The forensic psychology team worked well to oversee and support a small number of very challenging prisoners who were struggling to progress, including some who were serving indeterminate sentences.

- 6.31 There was a range of recovery-based group work programmes, brief interventions and one-to-one work to help those with substance misuse related needs (see paragraph 4.81).
- 6.32 The establishment was not funded for a prison employment lead, and work to enhance prisoners' job readiness skills and employment opportunities on release was limited (see paragraph 5.29).

Specialist units

Expected outcomes: Personality disorder units and therapeutic communities provide a safe, respectful and purposeful environment which allows prisoners to confront their offending behaviour.

Offender personality disorder units, including psychologically informed planned environments

- 6.33 The national offender personality disorder (OPD) pathway services continued to offer a very good support to about 100 prisoners who had complex emotional, relationship and behavioural needs. Provision included a PIPE and the Swaleside Outreach Service (SOS). These services followed national standards and were overseen by a dedicated prison manager and senior psychologists from Oxleas. OPD prison officers were well trained and supported by psychology colleagues. Care was planned collaboratively through joint referral meetings and multi-disciplinary assessments.
- 6.34 The PIPE environment offered cooking, recreation, group spaces, and outdoor areas for horticulture and animal care, where residents practised positive coping skills. These prisoners committed to a two-year programme of assessments and therapies, with the option to rejoin later if needed.
- 6.35 The SOS provided a therapeutic setting on a sessional basis. Psychologists and officers also supported men on wings to manage challenging behaviours.
- 6.36 Prisoners we spoke to told us it was hard to confront their behaviours but valued the support they received to help them to do so. Outcomes data showed OPD staff helped reduce challenging behaviours effectively.

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.

- 6.37 In the last year, an average of 13 prisoners had been released directly into the community each month. Swaleside was not a designated

resettlement prison and therefore not resourced to deliver support aimed at preparation for release.

- 6.38 The prison had done its best, with the resources it had, to meet these challenges. For example, the monthly resettlement meeting chaired by the OMU hub manager aimed to ensure outstanding needs had been identified and were being dealt with. A sequencing board had recently been introduced to provide oversight and practical assistance for those with less than two years left to serve.
- 6.39 There was an informal agreement reached with external staff to deliver ad-hoc support, including a resettlement worker from another prison and help for prisoners to apply for a bank account and personal identification.
- 6.40 We saw some examples of good work between POMs and COMs to plan for prisoners' release, but there were gaps, and men were not always kept informed about what was being done to support them, due in part to delays from COMs. In some cases, important information such as release addresses and reporting requirements were not confirmed until very late in the sentence creating unnecessary worry and anxiety for prisoners.
- 6.41 The prison's data showed most prisoners had an address to go to on the first night of release. The majority went to a probation approved premises as a condition of the licence, which was appropriate for their risk. However, 12 prisoners had left the prison homeless in the previous year.
- 6.42 Reception release arrangements were basic but efficient. There was no facility for prisoners to charge their mobile phones and, disappointingly, some prisoners we observed were not fully aware of their licence conditions until the day of release. There was a limited supply of donated clothing for those who might need it. Those not being met at the gate were offered transport to the local train station for onward travel.

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

Fourteen prisoners had died at Swaleside in the previous two years, including seven whose deaths were self-inflicted. Ongoing weaknesses included inconsistent support for prisoners at risk, a failure by some night staff to carry anti-ligature knives, slow responses to cell bells and inadequate reviews of Coroners' and PPO recommendations.

Not addressed

Levels of violence remained high and investigations into violent incidents were often delayed and of poor quality.

Not addressed

Key concerns

The routine use of strip-searching, alongside the use of a body scanner, was sometimes excessive and unnecessary.

No longer relevant

Drugs were too easy to obtain and measures to reduce supply were not comprehensive or effective.

Not 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 concerns

Many staff lacked confidence and assertiveness in their management of prisoners. Supervising officers did not provide sufficient visible support on many wings.

Not addressed

Key concerns

Key work sessions were increasing in number but most lacked substance or quality and many were little more than occasional welfare checks.

Not addressed

Nearly all wing kitchens were closed, depriving the predominantly long-term prisoner group of the incentive of self-catering and the opportunity for developing life and social skills.

Partially addressed

Work to support fair treatment and inclusion remained weak. The experiences of the diverse prisoner group were poorly understood and disproportionality was not systematically identified or addressed.

Not addressed

Some aspects of clinical governance were weak and did not ensure patient safety. Record keeping was poor, medicines administration and regimes did not meet national guidance, and some Prison and Probation Ombudsman recommendations had not been embedded.

Partially addressed

Prisoners did not have access to an adequate range of psychological therapeutic interventions and waiting times for those that were available were too long.

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 not sufficiently good against this healthy prison test.

Priority concerns

Prisoners' attendance rates at education, skills and work had not improved over time and were too low. Too few prisoners developed positive attitudes towards education and work.

Not addressed

Key concerns

The daily regime was restricted because of staff shortages, and a lack of teachers and instructors significantly impacted prisoners' engagement with work and activities.

Not addressed

Careers information, advice and guidance were ineffective and did not inform a coherent plan for prisoners to help develop the knowledge, skills, and behaviour prisoners needed to be successful in their progression. New arrivals to the prison waited too long to be allocated to education, skills or work.

Partially addressed

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.

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 few progression opportunities, and many category C prisoners were unable to transfer to a more suitable prison because of national population pressures. There was inadequate one-to-one work to mitigate these systemic problems.

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 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 \(justiceinspectorates.gov.uk\)](https://www.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:

Charlie Taylor	Chief inspector
Sara Pennington	Team leader
Sumayyah Hassam	Inspector
Rick Wright	Inspector
Jade Richards	Inspector
Harriet Leaver	Inspector
Jonathan Tickner	Inspector
Paul Rowlands	Inspector
Tareek Deacon	Researcher
Emma King	Researcher
Phoebe Dobson	Researcher
Shaun Thomson	Lead health and social care inspector
Paul Tarbuck	Health and social care inspector
Malcolm Irons	General Pharmaceutical Council inspector
Jacob Foster	Care Quality Commission inspector
Nick Crombie	Ofsted inspector
Viki Faulkner	Ofsted inspector
Dave Baber	Ofsted inspector
Yvette Howson	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.

ACCT

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

Building Choices

An accredited HMPPS cognitive-behavioural programme, delivered through group and one-to-one sessions. It focuses on developing skills in emotion management, healthy thinking, relationships, sense of purpose, and, where relevant, healthy sexual behaviour. The programme is tailored to individual risk and need, including those with learning disabilities or challenges, and aims to support positive change and reduce reoffending.

Care Quality Commission (CQC)

The independent regulator of health and social care in England.

Certified normal accommodation (CNA)

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.

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.

Crown Prosecution Service (CPS)

Prosecutes criminal cases that have been investigated by the police and other investigative organisations in England and Wales.

Discrimination incident reporting form (DIRF)

A form that prisoners can use to report discrimination.

His Majesty's Prison and Probation Service (HMPPS)

Carries out sentences given by the courts, in custody and the community, and rehabilitates people in its care through education and employment. HMPPS is an executive agency, sponsored by the Ministry of Justice.

Home detention curfew (HDC)

Early release 'tagging' scheme.

Incentivised substance-free living (ISFL)

Dedicated prison units for prisoners who commit to living drug-free. Residents agree to a behavioural compact, undergo regular drug testing, and receive incentives such as extra time out of cell or access to activities. ISFL units provide a structured environment that promotes recovery, positive relationships, and healthier choices.

Indeterminate sentence for public protection (IPP)

Given to offenders who posed a significant risk of serious harm to the public. Although the IPP sentence was abolished in 2012, thousands of people subject to such a sentence are still in prison.

Insiders

Prisoners who introduce new arrivals to prison life.

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.

Listener

Prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners.

Mandatory drug testing (MDT)

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

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.

National Early Warning Score (NEWS2)

System used in health care to assess and identify early signs of deterioration in a patient's condition.

Offender assessment system (OASys)

Assessment system for both prisons and probation, providing a framework for assessing the likelihood of reoffending and the risk of harm to others.

Offender management in custody (OMiC)

Entails prison officers undertaking key work sessions with prisoners and case management, which established the role of the prison offender manager (POM) from 1 October 2019. On 31 March 2021, a specific OMiC model for male open prisons, which does not include key work, was rolled out.

Official prison video conferencing (OPVC)

Available in all prisons to enable remote court hearings, as well as official visits and meetings (including legal and probation visits). OPVC is not used for social visits.

Prison Advice and Care Trust (PACT)

Supports prisoners, people with convictions and their families across England and Wales.

PAVA

Pelargonic acid vanillylamide – incapacitant spray classified as a prohibited weapon by section 5(1) (b) of the Firearms Act 1988.

PIPE

Psychologically informed planned environment. PIPEs are specifically designed living areas where staff specially trained in psychological understanding aim to create a supportive environment that can facilitate the development of prisoners with challenging offender behaviour needs.

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 social video calling

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

Shannon Trust

Charity that supports people in prison to learn to read.

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).

Storybook Dads

Enables prisoners to record a story for their children.

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



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

The inspection of health services at HMP Swaleside 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 \(justiceinspectorates.gov.uk\)](http://justiceinspectorates.gov.uk)). The Care Quality Commission issued a request for an action plan following this inspection.

Action plan request

Provider

Oxleas NHS Foundation Trust

Location

HMP Swaleside

Location ID

RPGXM

Regulated activities

Diagnostic and screening procedures and Treatment of disease, disorder or injury.

Action we have told the provider to take

This notice shows the regulations that were not being met. The provider must send CQC a report describing what action it is going to take to meet these regulations.

Regulation 12 Safe care and treatment

How the regulation was not being met:

- Medicine administration on the Care and Separation Unit (CSU) was unsafe.
- Nursing staff and the prisons operational staff told us secondary dispensing of medicines to patients located in the CSU was commonplace. Staff described separating individually prescribed medicines into small plastic bags in the medication room before transporting them to the CSU and administering to patients.
- Patients with known wounds did not always receive safe care.
- Wound assessments were not consistently recorded. Patients with known wounds did not always have a record of the size, location, grade or other pertinent information required to assess the development or healing process of each wound.
- Patients with known wounds did not always have clear care plans in place to guide staff when caring for people with wounds.
- Patients with known wounds did not always have their dressings changed at regular intervals. For example, one patient required their dressings changed every two days. We found multiple gaps of over two days where the dressings were not changed.
- Some patients with wounds suffered worsening healthcare conditions due to poor care. For example, one patient whose wounds were not consistently cared for appropriately later required hospital treatment.

Appendix IV Further resources

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

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.

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Printed and published by:
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3rd floor
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