Report on an independent review of progress at

HMP Channings Wood

by HM Chief Inspector of Prisons

1–3 July 2019

This progress visit was carried out in partnership with the following bodies:





Crown copyright 2019

This publication, excluding logos, is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/

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

Contents

About this report 5

Key findings 7

Section 1. Chief Inspector's summary 9

Section 2. Progress against the key concerns and recommendations and Ofsted themes 11

Section 3. Appendix 23

Review team 23

Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

About this report

A1 Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

A2 All visits carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

A3 Independent reviews of progress (IRPs) are a new type of visit designed to improve accountability to ministers about the progress prisons make towards achieving HM Inspectorate of Prisons' recommendations in between inspections. IRPs will take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny, and will focus on a limited number of the recommendations made at the inspection. IRPs will therefore not result in assessments against our healthy prison tests.[1]

A4 The aims of IRPs are to:

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

A5 This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each recommendation we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in September 2018 for further detail on the original findings.[2]

IRP methodology

A6 IRPs will be announced at least three months in advance and will take place eight to 12 months after the full inspection. When we announce an IRP, we will identify which recommendations we intend to follow up (usually no more than 15). Depending on the recommendations to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

---

1 HM Inspectorate of Prisons' healthy prison tests are safety, respect, purposeful activity and rehabilitation and release planning. For more information see our website: https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/

2 The report of the 2018 inspection is available at: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/02/Channings-Wood-Web-2018.pdf

A7 During our three-day visit, we will collect a range of evidence about the progress in implementing each selected recommendation. Sources of evidence will include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

A8 Each recommendation followed up by HMI Prisons during an IRP will be given one of four progress judgements:

- **No meaningful progress**
  Managers had not yet formulated, resourced or begun to implement a realistic improvement plan for this recommendation.

- **Insufficient progress**
  Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken had not yet resulted in any discernible evidence of progress (for example, better systems and processes) or improved outcomes for prisoners.

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

- **Good progress**
  Managers had implemented a realistic improvement strategy for this recommendation and had delivered a clear improvement in outcomes for prisoners.

A9 When Ofsted attends an IRP its methodology will replicate the monitoring visits conducted in further education and skills provision. Each theme followed up by Ofsted will be given one of three progress judgements.

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

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

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

Key findings

S1 At this IRP visit, we followed up 13 of the 60 recommendations made at our most recent inspection and made judgements about the degree of progress achieved to date.

S2 We judged that there was good progress in six recommendations, reasonable progress in five recommendations and insufficient progress in two recommendations. None of the recommendations were judged to have made no meaningful progress. A summary of the judgements is as follows.

Figure 1: Progress on recommendations from 2018 inspection (n=13) [3]

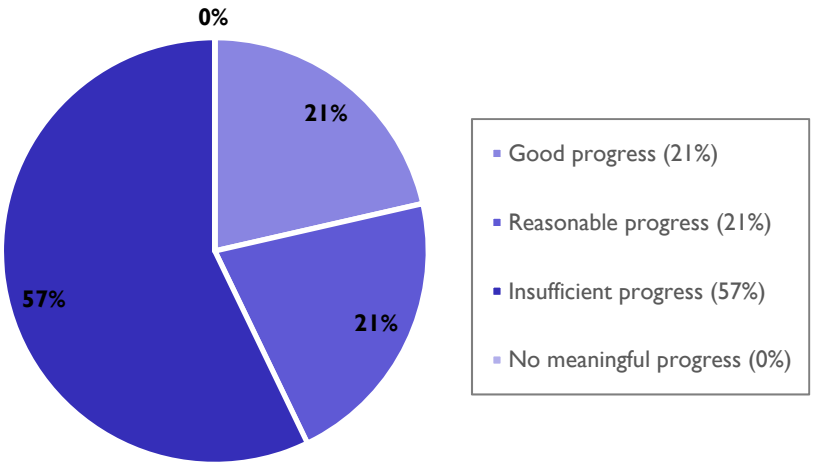


Figure 2: Judgements against HMI Prisons recommendations from 2018 inspection

Recommendation	Judgement
The governor should develop a coordinated strategy to improve outcomes across the main measures of safety that is clearly understood by staff at all levels and across all disciplines. The strategy should be led by senior managers and should include clear goals and measures of success and articulate clearly how improvement will be achieved. (S41)	Reasonable progress
A clear set of standards for daily living that address living conditions, personal standards, behaviour and how individuals conduct themselves towards others should be applied consistently across the prison. Such standards should be modelled pro-socially by managers and staff who should be accountable for improvements. (S42)	Good progress
The poor structural state of the living blocks should be addressed; windows and broken furniture should be replaced, privacy screens should be installed in showers, buildings should be made waterproof. Prisoner cleaners and painters should have clear job descriptions and their work should be monitored by staff and managers. (S43)	Insufficient progress

[3] This pie chart excludes any recommendations that were followed up as part of a theme within Ofsted's concurrent prison monitoring visit.

The process to refer prisoners to the interdepartmental risk management team should be improved to ensure that all high-risk of harm cases due for release are reviewed regularly. MAPPA levels should be confirmed in time for the prison to be fully involved in multi-agency planning for release. (S45)	Good progress
Vulnerable prisoners should be kept safe during their early days and their experience and induction should be equivalent to their mainstream peers. (1.6)	Good progress
All incidents should be reported to ensure that the prison has an accurate picture of drug misuse, violence and self-harm. (1.20)	Good progress
The prison should ensure that the MDT and suspicion testing programmes are adequately resourced to undertake all testing within required timescales and in a way that minimises their predictability. (1.45, repeated recommendation 1.32)	Insufficient progress
The prison should produce and implement a comprehensive action plan addressing the underlying causes of self-harm. (1.52)	Reasonable progress
Staff on living blocks 1,3 and 4 should be out of unit offices providing appropriate supervision of prisoners and challenging poor behaviour. (2.5)	Good progress
The equality action plan should be comprehensive and should be monitored regularly by senior managers to ensure that required actions are carried out. (2.35)	Reasonable progress
Clinical governance arrangements should deliver effective and safe staffing, robust audit and oversight, regular clinical supervision and a qualitative, well-advertised complaints system which provides timely and clear responses, including how to escalate unresolved concerns. (2.62)	Good progress
The reducing reoffending strategy should be based on an up-to-date needs analysis which includes data from OASys and addresses the needs of significant groups of prisoners within the population. (4.18)	Reasonable progress
There should be routine oversight of the quality of offender management, including contact levels and case progression. (4.19, repeated recommendation 4.12)	Reasonable progress

S3 Ofsted judged that there was significant progress in no themes, reasonable progress in three themes and insufficient progress in no themes.

Figure 3: Judgements against Ofsted themes[4] from 2018 inspection

Ofsted theme	**Judgement**
What progress have leaders and managers made in improving education, skills and work to meet the needs of all groups of prisoners, increase their participation, attendance and punctuality, and ensure that appropriate advice and guidance are available for them prior to release?	Reasonable progress
What progress have leaders and managers made in improving teaching, learning and assessment so that each prisoner's learning is well planned, builds on their prior knowledge and aspirations, and involves effective feedback that helps them make at least good progress?	Reasonable progress
What progress have leaders and managers made in improving outcomes for prisoners, including identifying and recording their development of personal and work skills, their achievement of functional skills qualifications, and the standards of their work?	Reasonable progress

[4] Ofsted's themes incorporate the key concerns at the previous inspection in respect of education, skills and work.

Section 1. Chief Inspector's summary

1.1 At our inspection of HMP Channings Wood in 2018, we made the following judgements about outcomes for prisoners.

Figure 2: HMP Channings Wood healthy prison outcomes 2016 and 2018.



1.2 HMP Channings Wood is a training and resettlement prison near Newton Abbot in Devon, holding up to 724 adult men. At the inspection in September 2018, we assessed outcomes for prisoners as not sufficiently good across all four of our healthy prison tests – the same assessment as at the previous inspection in 2016. We found that inconsistency of outcomes was a recurrent theme. This was best exemplified in varying standards being accepted across the different accommodation blocks, and in partial or uncoordinated implementation of initiatives designed to improve outcomes. The enthusiasm and openness of managers needed to be supplemented with active, visible leadership, ensuring that improvement was achieved and sustained.

1.3 This independent review of progress (IRP) found that the establishment and its leaders had taken their cue very positively from our findings and recommendations, and within nine months had moved ahead in the great majority of the areas where we had identified weaknesses. In particular, our call for much greater coordination and consistency of standards had been heeded. Reasonable or good progress had been made in carrying out 11 of the 13 recommendations which we reviewed in this IRP. Of the two recommendations on which we judged that insufficient progress had been made, one (on drug testing) was to be seen in the context of improved effectiveness in the overall work to reduce the supply of illegal drugs, and the other (on the physical condition of living units) depended to a large extent on budgetary issues, where other priorities had proved pressing on security grounds.

1.4 A single senior manager was now driving forward a coordinated strategy for safety. Analysis and use of data had improved and there was better use of individual management plans, both to encourage positive behaviour and to support the vulnerable. The level of violence against staff had decreased, and in other areas the figures relating to violence did not show any increasing trends. There were also some signs that use of new psychoactive substances, and of drugs in general, were on the decrease. Vulnerable prisoners said that they were now safer on their induction unit.

1.5 The physical condition of many of the accommodation units was still too poor, in spite of better efforts to paint and clean them. Showers were a conspicuous example, despite refurbishment on one unit. However, the stark contrast which had been noticed in 2018 between living blocks 1, 2, 4 and the rest, both in their physical state and in the standards evidently regarded as acceptable by staff and managers in those areas, had largely disappeared. More coordinated management was having an impact, although there was a long way to go before the accommodation could satisfy basic criteria of decency.

1.6 Leadership and governance in health and social care had improved; good support had been given from regional level to sustain this. A more satisfactory complaints system had been established. There had been some recent improvements in equality work, showing promise but not yet well established.

1.7 Ofsted found some improvements in education, skills and work; they judged that there had been reasonable progress in the three themes, of senior leaders' prioritising of the quality of education, skills and work; aspects of teaching, learning and assessment; and outcomes for prisoners.

1.8 Work to reduce reoffending had already become more consistent, with layers of assurance added to ensure that public protection responsibilities were carried out thoroughly, especially for high-risk prisoners approaching release, and more active supervision of the work of staff in the offender management unit. A needs analysis had been carried out, although attention was still needed to the issues raised in our 2018 report; moreover, the improved supervision needed to lead to real outcomes in achieving regular contact by offender supervisors with those on their caseload was now required, so as to support progression through the sentence.

1.9 At this IRP, we found strong leadership beginning to bear fruit in real improvements to almost all of the areas which we followed up from our recent inspection. There was a clear sense of coordination and of direction; this was attested to not just by managers, but also by staff, and by some prisoners as well. Most staff whom we met or observed, including many in their first year of service, were engaged, appreciative of the new management approaches and well-motivated in their work.

Peter Clarke CVO OBE QPM July 2019
HM Chief Inspector of Prisons

Section 2. Progress against the key concerns and recommendations and Ofsted themes

The following provides a brief description of our findings in relation to each recommendation followed up from the full inspection in 2018. The reference numbers at the end of each recommendation refer to the paragraph location in the full inspection report.

Safety

Concern: Levels of violence and self-harm were too high, much of it linked to drug misuse, and too many incidents were not reported. There were numerous policies designed to address violence, manage perpetrators, support victims and address the serious drug problem. However, there was no oversight of this disjointed work and much of it had not been implemented effectively. Neither the safety nor drug strategy identified or adequately addressed factors increasing the demand for drugs such as poor living conditions, regime curtailment and a lack of staff supervision.

Recommendation: The governor should develop a coordinated strategy to improve outcomes across the main measures of safety that is clearly understood by staff at all levels and across all disciplines. The strategy should be led by senior managers and should include clear goals and measures of success and articulate clearly how improvement will be achieved. (S41)

2.1 A safety strategy was now in place and widely advertised. It was supported by a multidisciplinary approach to managing safety, and a single head of safety was now in post, coordinating all safety work. There was a clear focus on basic safety issues, and a drive to treat prisoners according to their individual needs. There had been improvements to the physical security of the prison, to measures to reduce the availability of illicit substances and to the working day, all of which were helping to improve safety.

2.2 The return of dedicated senior officers to all wings had been a positive move and meant that the residential staff were at the heart of all issues involving safety, supported by a proactive safer custody team. The amount of violence against staff had been dropping, while violence against prisoners remained roughly level. The amount of evidence-based searching had improved.

2.3 Prisoners with a variety of needs, including victims of violence, self-isolators and prisoners with complex needs, were supported through individual plans, by wing staff as well as the safer custody team. A weekly 'safer custody intervention meeting' brought all departments together to discuss these prisoners, as well as those who were on assessment, care in custody and teamwork (ACCT) case management processes for prisoners at risk of suicide or self-harm or being managed under the 'Challenge, Support and Intervention Plan' (CSIP)[5] process.

2.4 The CSIP process was now being used in a small number of cases and we were confident that all incidents of violence were being investigated, most within 72 hours. The standard of investigations was inconsistent, but work was in hand to develop staff skills in this area.

[5] The Challenge, Support and Intervention Plan (CSIP) is a system used by some prisons to manage the most violent prisoners and support the most vulnerable prisoners in the system. Prisoners who are identified as perpetrators of serious or repeated violence, or who are vulnerable due to being the victim of violence or bullying behaviour, are managed and supported on a plan, with individualised targets and regular reviews.

Prisoner debt remained a major destabilising factor in relation to safety. A debt management policy had recently been introduced but was not yet embedded. During their induction, prisoners were alerted to the dangers of incurring debt. The use of new psychoactive substances[6] had declined, and the mandatory drug testing rate had shown a reduction in recent months.

2.5 An action plan to reduce levels of self-harm had been introduced recently, but actions arising from it were not yet well advanced. The amount of self-harm did not appear to have increased further since the previous inspection.

2.6 We considered that the prison had made reasonable progress against this recommendation.

Early days in custody

Concern: At the last inspection, there had been a stark difference between the first night and induction experience of mainstream prisoners and that of vulnerable prisoners. Vulnerable prisoners spent their first few weeks on living block 1, which was an unsuitable environment for new prisoners. The unit was in a squalid condition: communal areas were in a poor state of repair, many windows were broken and prisoners were regularly placed in dirty cells lacking basic items such as pillows, televisions and kettles.

Recommendation: Vulnerable prisoners should be kept safe during their early days and their experience and induction should be equivalent to their mainstream peers. (1.6)

2.7 The induction experience of vulnerable prisoners was now comparable with that of mainstream prisoners. They had access to all services and support mechanisms that were available to mainstream prisoners. A comprehensive recording system now ensured that all prisoners received the full induction package, and this was signed off by the prisoner, peer workers and staff.

2.8 Vulnerable prisoners were still housed on living block 1. There were ongoing maintenance issues there, but the wing was now cleaner and brighter, owing to continuing painting and decorating work. Cells for new arrivals were appropriately furnished and all basic items were provided. There was a comprehensive risk assessment process for prisoners whose alleged vulnerability did not arise from the nature of their offence, and there were now fewer such prisoners on living block 1, which had reduced the level of bullying considerably. This meant that prisoners who were vulnerable by virtue of their offence were safeguarded from non-vulnerable prisoners coming onto the wing to live. In addition, the prison had introduced formal well-being checks during the first night in custody.

2.9 Vulnerable prisoners we spoke to who had recently completed the induction process were complimentary about the support they had received, both from the staff and a dedicated group of prisoner peers.

2.10 We considered that the prison had made good progress against this recommendation.

---

[6] The term 'new psychoactive substances' generally refers to synthetic cannabinoids, a growing number of man-made mind-altering chemicals that are either sprayed on dried, shredded plant material or paper so they can be smoked or sold as liquids to be vaporized and inhaled in e-cigarettes and other devices.

Managing behaviour

Concern: Levels of violence against staff and prisoners had increased since the previous inspection. Although the reported data indicated that violence was no higher than in similar establishments, we found that many violent incidents had not been recorded on the Her Majesty's Prison and Probation Service incident reporting system. The establishment had failed to address this issue, despite being aware of it since late 2017.

Recommendation: All incidents should be reported to ensure that the prison has an accurate picture of drug misuse, violence and self-harm. (1.20)

2.11 The prison had introduced a comprehensive programme of auditing the incident reporting system (IRS), to ensure that all incidents were recorded accurately. This involved a daily staff briefing, ensuring that mandatory actions from the previous 24 hours had been completed. A daily check by the orderly officer, a daily senior manager tasking meeting, a daily duty governor check and a weekly senior management audit of observation books against the IRS now took place. If incidents were found to be unreported, this was corrected, and guidance and support were given to the staff involved.

2.12 During a recent IRS audit, only four incidents had been found to be unreported; three of these had involved low-level self-harm, where inexperienced staff had been unaware of the need to report for IRS purposes.

2.13 We considered that the prison had made good progress against this recommendation.

Security

Concern: There was no coordinated effort and little vigour to implement and drive the drug and supply reduction strategy. Drug testing prioritised mandatory drug testing (MDT). This led to predictability in testing arrangements and very few suspicion tests being carried out, which would have yielded more useful results.

Recommendation: The prison should ensure that the MDT and suspicion testing programmes are adequately resourced to undertake all testing within required timescales and in a way that minimises their predictability. (1.45, repeated recommendation 1.32)

2.14 Resourcing for drug testing had not improved, and it depended on the unreliable availability of trained staff from day to day. Random testing was carried out in line with the set targets, but very few tests on the basis of suspicion were carried out, and in some months none.

2.15 There was now a comprehensive drug strategy, and a clear understanding of the current issues. The prison had justifiably prioritised the main risk areas, including the layout of the site, which enabled illicit items easily to be thrown over and retrieved. Actions taken in conjunction with the police had reduced this threat substantially and were likely to have reduced the flow of drugs into the establishment. The prison had also put additional security measures in place to ensure that prisoners undertaking release on temporary licence were safeguarded from pressure to bring drugs in, and that perpetrators were challenged. Although the prison had done little targeted testing for drugs, targeted searching had improved, and 90% of requested searches had been completed in the previous six months.

2.16 We considered that the prison had made insufficient progress against this recommendation.

Suicide and self-harm prevention

Concern: The number of self-harm incidents over the previous six months had more than doubled since the previous inspection and was very high. The prison's action plan to reduce self-harm did not address Prison and Probation Ombudsman (PPO) recommendations or the coordinated action necessary to disrupt illicit activity.

Recommendation: The prison should produce and implement a comprehensive action plan addressing the underlying causes of self-harm. (1.52)

2.17 The prison had done much work on understanding the drivers of self-harm, which were monitored for trends monthly. There was some evidence that debt caused by illicit items was the main driver, followed by mental health issues. There was also good analysis of the location and timing of self-harm incidents in the safer custody team's monthly assurance report. Self-isolators and prolific self-harmers were identified and managed through the complex needs meeting. A safer custody analyst had recently been appointed.

2.18 Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) and, in particular, safer custody representatives provided a good source of information about the issues faced by prisoners that might drive them to self-harm, while respecting confidentiality. These prisoner representatives attended the monthly safer custody meetings.

2.19 The prison had produced an action plan to reduce levels of self-harm, with actions driven by the understanding of causes. The plan had actions, a named person responsible for each action, and timescales. We were told that the plan was monitored at the monthly safer custody meeting. Most of the proposed actions were reasonable, although not many extended beyond the next one to two months, and they were not yet consistently being carried out or updated regularly and reliably.

2.20 Recommendations by the PPO, resulting from their investigations into deaths at the establishment, had been progressed through the monthly safer custody meeting, and were all recorded as having been completed.

2.21 We considered that the prison had made reasonable progress against this recommendation.

Respect

Concern: There were stark differences in culture and conditions across the different living blocks. Half of the prisoners at Channings Wood lived in a clean and decent environment, while the other half lived in very poor conditions. In living blocks 5 to 8, living conditions were much better. Staff set appropriate standards for prisoners and challenged unacceptable behaviour; they encouraged and supported prisoners to take personal responsibility. By contrast, standards and outcomes on living blocks 1, 3 and 4 were poor.

Recommendation: A clear set of standards for daily living that address living conditions, personal standards, behaviour and how individuals conduct themselves towards others should be applied consistently across the prison. Such standards should be modelled pro-socially by managers and staff who should be accountable for improvements. (S42)

2.22 A single head of residence had been appointed recently, and was leading the development of a more unified approach in living conditions and standards of behaviour across the prison. This included a more proactive approach from managers. Prisoners and staff said that

managers were more visible and effective in supporting them to provide consistent standards.

2.23 Cell conditions on living blocks 1, 3 and 4 had improved as more effective systems for checking the physical conditions of cells had been implemented. Broken furniture was replaced, with repairs reported and resolved more quickly. Cells with broken windows and observation panels were now put out of use until repaired. Further development and improved quality assurance of these systems was planned. There was still much to be done to improve the overall living conditions (see also paragraphs 2.31 to 2.37).

2.24 Communal areas across the prison were clean, with many areas newly painted, particularly on living blocks 1,3 and 4, which were brighter and had a more decent environment than at the time of the previous inspection. The stark contrast between living blocks was now less evident.

2.25 Custodial managers and supervision officers had been appointed to all wings, to support staff and to model methods of engagement with prisoners. Staff told us that the presence of these managers had increased their confidence.

2.26 A communications strategy, 'strategy of choices', was being rolled out across the prison and was being actively reinforced by senior managers to develop staff confidence in building positive relationships with prisoners and the ability to challenge unacceptable behaviour, including on living blocks 1, 3 and 4. This work was at an early stage and not yet embedded.

2.27 We considered that the prison had made good progress against this recommendation.

Staff-prisoner relationships

Concern: While relationships between staff and prisoners on living blocks 5, 6, 7 and 8 were generally good, on living blocks 1, 3 and 4 staff were found congregating in offices while unlocked prisoners were left unsupervised. Poor living conditions and bad behaviour went unchallenged.

Recommendation: Staff on living blocks 1, 3 and 4 should be out of unit offices providing appropriate supervision of prisoners and challenging poor behaviour. (2.5)

2.28 Staff on living blocks 1, 3 and 4 told us that they received regular reminders not to congregate in unit offices, and that the residential custodial managers and supervisory officers now located on their living blocks supported them in doing this. In addition, each day senior managers were allocated to living blocks over the lunch period, to monitor activities and encourage staff to engage with prisoners.

2.29 Prisoners on living blocks 1, 3 and 4 told us that officers' availability on the living blocks had improved over recent months and that most staff were helpful. We observed officers mostly busy on the units, and not congregating in unit offices. Staff told us that they encouraged prisoners to clean themselves and their cells, and we saw little poor hygiene. Bad behaviour was not commonplace, suggesting that it was now challenged more effectively.

2.30 We considered that the prison had made good progress against this recommendation.

Living conditions

Concern: Many of the residential buildings were in poor physical condition, dirty and poorly maintained. There were leaking roofs, broken furniture and sanitation, missing windows, poorly screened showers and damaged flooring.

Recommendation: The poor structural state of the living blocks should be addressed; windows and broken furniture should be replaced, privacy screens should be installed in showers, buildings should be made waterproof. Prisoner cleaners and painters should have clear job descriptions and their work should be monitored by staff and managers. (S43)

2.31 There had been limited improvements to the structural state of the living blocks but, overall, the condition of the buildings remained poor. This had been largely due to restrictions in funding.

2.32 Windows had been either repaired or made safe, and two association rooms on living block 3 had been refurbished, including repairs to the roof areas to prevent the ingress of water, although water still entered on living blocks 6 and 7, where cells remained out of use as a consequence.

2.33 One shower room on living block 5 had been refurbished, including adjustments for those with mobility difficulties. Work to refurbish the other shower room on living block 5 was due to start imminently. However, funding to replace showers on the other blocks had been diverted to fund additional security measures, and they remained in very poor condition, without privacy screens and needing frequent painting to prevent the build-up of mildew.

2.34 Flooring remained in poor condition in many areas.

2.35 There was now a more organised approach to checking and chasing repairs; this had resulted in these being completed more quickly, and plans to embed more effective monitoring were well developed.

2.36 Job descriptions had recently been issued for painters and cleaners, whose work was of a reasonable standard and overseen by the facilities management staff.

2.37 We considered that the prison had made insufficient progress against this recommendation.

Equality, diversity and faith

Concern: Equality and diversity procedures had deteriorated since the previous inspection. The equality action team met only quarterly, and attendance at meetings was poor. The newly appointed equality officer had been unable to take up her post because of staffing pressures. The equality action plan was limited and there was little to indicate that it was being monitored adequately or that required actions were being carried out.

Recommendation: The equality action plan should be comprehensive and should be monitored regularly by senior managers to ensure that required actions are carried out. (2.35)

2.38 An improved equality action plan had been implemented and covered most areas, including actions fed through from consultation with minority groups. However, actions were not always sufficiently specific, measurable or time bound, and although prisoner representatives

had been appointed for each protected characteristic, meetings of their forums were not yet regular.

2.39 The action plan was reviewed by the equality action team, which had increased the frequency of its meetings from quarterly to monthly. Chaired by the governor, this meeting was well attended, including by other members of the senior management team and prisoner representatives. However, it had been taking place for only three months, and there was still a need to develop and embed it. For example, the collection of local and up-to-date monitoring data to help to focus actions had only just begun and was not yet sufficiently comprehensive.

2.40 A full-time equality officer was in post. Although she had made a good start at coordinating and progressing equality work, she was often deployed to other duties. A custodial manager for equality and a deputy equality officer had recently been appointed, but had not yet started in these roles.

2.41 We considered that the prison had made reasonable progress against this recommendation.

Health, well-being and social care

Concern: Local clinical governance systems were not driving improved outcomes for patients. Primary care staffing was stretched and not always able to meet demand. Clinical supervision was not routinely available, although some group reflective sessions were facilitated. Clinical audit was limited. An independent health complaints system had been introduced but many complaints had not been responded to and a backlog had developed. Responses were not always adequate.

Recommendation: Clinical governance arrangements should deliver effective and safe staffing, robust audit and oversight, regular clinical supervision and a qualitative, well-advertised complaints system which provides timely and clear responses, including how to escalate unresolved concerns. (2.62)

2.42 Overall, this was a positive review, conducted jointly by the Care Quality Commission (CQC) and Her Majesty's Inspectorate of Prisons. It included a follow-up inspection of the four requirement notices issued by the CQC following the previous inspection. A separate report will be published on the CQC website, with the full details of this follow-up inspection. All four requirement notices were deemed to have been achieved.

2.43 The overall governance of health care had improved with the progression of a comprehensive and active action plan. Partnership, contracts and local delivery board meetings remained robust and well supported by the NHS England commissioner.

2.44 The oversight of the service by the new regional governance lead and the regional manager had mitigated most of the risk created by the head of health care vacancy, to which an appointment had recently been made. This regional presence had enabled the continued improvements in governance to be progressed.

2.45 There was a much-improved process for raising concerns or complaining about health services; more recent changes to the process needed more time to embed.

2.46 Audits had been conducted, in line with the agreed Care UK programme, with associated action plans. This represented an improvement on the previous inspection.

2.47 Clinical supervision had also improved. This was more evident in some staff groups than others and was appropriately facilitated by Care UK. Previous specialist supervisory groups had also been sustained.

2.48 Staffing levels had improved and, although the allocation and utilisation of staff were not always at their most efficient, there was no evidence that this affected patient outcomes.

2.49 We considered that the prison had made good progress against this recommendation.

Education, skills and work[7]

Theme 1

What progress have leaders and managers made in improving education, skills and work to meet the needs of all groups of prisoners, increase their participation, attendance and punctuality, and ensure that appropriate advice and guidance are available for them prior to release?

2.50 At the previous inspection, senior leaders had not given the quality of education, skills and work enough priority. Prisoners' punctuality and attendance at education, skills and work sessions were poor. They received insufficient advice and guidance on their skills or career progression.

2.51 Since the previous inspection, leaders and managers had prioritised improving the quality of the education, skills and work provision sufficiently. Prison leaders were working closely and productively with managers from the education and training provider.

2.52 Leaders had implemented new strategies which had progressively improved prisoners' attendance at sessions, rising to just above 90% in recent weeks. Prisoners' punctuality was improving due to the increased efficiency and effectiveness of movement arrangements, but was not yet consistently good.

2.53 Leaders had reviewed and overhauled the process for allocating prisoners to activities, through wider staff representation and more accurate risk assessments. The impact of this process had yet to be seen.

2.54 Leaders and managers had introduced new programmes to meet the needs of vulnerable prisoners. These were particularly popular and well attended. There had been no functional skills English provision for this group for six months, but it was due to begin in August 2019. A newly appointed English teacher was recruiting from among the growing number of foreign national prisoners, to attend sessions in English language and writing skills.

2.55 Prisoners following Open University and distance learning courses received effective support. However, vulnerable prisoners on these courses now had less access to computers for essay writing, or the library for research.

2.56 Managers had implemented a carefully tailored resettlement programme for prisoners within 12 weeks of release. Prisoners' attendance at the wide range of training and information sessions offered was extremely high.

---

[7] Ofsted's thematic approach reflects the monitoring visit methodology used for further education and skills providers. The themes set out the main areas for improvement in the last inspection report.

2.57 Leaders had increased the number of activity places, but too many were undemanding wing-based roles. The number of unemployed prisoners and those refusing to engage with activities remained too high. Leaders had not yet ensured that most prisoners who started a session stayed to the end and did not depart for a different activity.

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

Theme 2

What progress have leaders and managers made in improving teaching, learning and assessment so that each prisoner's learning is well planned, builds on their prior knowledge and aspirations, and involves effective feedback that helps them make at least good progress?

2.59 At the previous inspection, several aspects of teaching, learning and assessment required improvement. Managers had subsequently implemented a strategy to develop the professional skills of teachers and vocational tutors, and this had begun to have a positive impact. For example, a thorough system of lesson observations had led to clear actions for individual and collective improvement in teaching and learning. Teachers' planning for learning now drew more closely on individuals' initial assessment and aspirations. Teachers and tutors more consistently set each prisoner meaningful targets and closely monitored their progress towards achieving them. Most prisoners had a good understanding of how well they were progressing and what they still needed to achieve. Teachers' verbal feedback to prisoners was constructive and encouraging, but their written feedback mostly involved praise and did not encourage them to improve their work further.

2.60 Prisoners in education and training sessions were on task and had learned how to take instructions and follow guidance. They received good individual coaching from their vocational tutors. Teachers and tutors made good use of well-trained peer mentors to support individuals' learning during sessions.

2.61 Prisoners' work targets in the tailoring and laundry workshops were clear and reflected real industrial practice. Prisoners' targets on vocational courses were too often broad and lacked challenge because they did not reflect their prior work experience and skills. Managers' target setting was weak in the hard landscaping provision.

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

Theme 3

What progress have leaders and managers made in improving outcomes for prisoners, including identifying and recording their development of personal and work skills, their achievement of functional skills qualifications, and the standards of their work?

2.63 At the previous inspection, outcomes for prisoners required improvement. Prisoners now behaved well while engaged in education, skills or work activities. They did not use poor language and were helpful to each other during the sessions.

2.64 A large proportion of prisoners who completed an accredited course achieved the qualification. The proportion of prisoners achieving functional skills qualifications had increased substantially in mathematics, and was now very high. However, the standard of prisoners' classroom-based work in entry-level mathematics lessons required improvement.

2.65 The standard of prisoners' work in vocational training was generally good, and very high in the wood mill and wood assembly. Vulnerable prisoners' portfolios on the business

enterprise course were well organised and contained high-quality written work, from draft through to final versions.

2.66 Prisoners in workshops and outside work parties wore appropriate protective equipment and paid good attention to health and safety. In barbering, most prisoners developed appropriate technical and customer service skills. Those in the cycle maintenance workshop developed useful practical skills in renovating bicycles. In horticulture, prisoners enjoyed tending flowers and vegetables.

2.67 Prison leaders had implemented a way to recognise and record the skills and behaviour that prisoners acquired in workshops, such as the laundry and tailoring workshops, but it was too complex and had fallen out of use. A new, much simpler system was implemented during the inspection.

2.68 In construction skills, practical horticulture and functional skills English, up to 40% of prisoners who started their course during 2018/19 did not complete it. Completion data for 2019 so far were not available. Prison leaders and managers had not implemented a strategy to raise the comparatively low participation and achievement rates of two black and minority ethnic groups.

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

Reducing risk, rehabilitation and progression

Concern: At the time of the previous inspection, a review of the reducing reoffending strategy was due and a prisoner survey had been completed as part of a needs analysis to inform the review. However, there was no plan to use offender assessment (OASys) data linked to offending, or to analyse the needs of specific groups of prisoners, such as those serving indeterminate sentences.

Recommendation: The reducing reoffending strategy should be based on an up-to-date needs analysis which includes data from OASys and addresses the needs of significant groups of prisoners within the population. (4.18)

2.70 A new needs analysis had been drawn up very recently on the basis of a prisoner survey, which had had a reasonable response rate of 43%. The analysis of the survey results and the resulting recommendations were generally appropriate. The reducing reoffending strategy had been updated accordingly, on the basis of changes in the new survey, but it was too soon to make any judgements on real progress.

2.71 A way of integrating up-to-date aggregate OASys data into this process had not yet been found. In addition, it was clear that not all the prisoners had up-to-date OASys reports, so any analysis done could only be partial. However, there was value in the needs analysis, even without such information.

2.72 The strategy contained two actions directed specifically to the needs of those with indeterminate sentences, the group identified in the inspection report as an example of those lacking a needs analysis.

2.73 We considered that the prison had made reasonable progress against this recommendation.

Concern: There was no evidence of management oversight of levels of contact between offender supervisors and the prisoners allocated to them.

Recommendation: There should be routine oversight of the quality of offender management, including contact levels and case progression. (4.19, repeated recommendation 4.12)

2.74 There was now consistent oversight of offender management by the senior probation officer, through a monthly one-to-one meeting with each of the probation officers and offender supervisors.

2.75 The notes of these meetings showed that their scope and quality were good, and the specific cases were talked about in depth, although there was still no clarity about the regularity of contact, or case progression across the whole population. Offender management unit staff said that contact with the prisoners on their caseload was not as frequent as they would desire, and that there were issues around prisoner progression. The lower level of contact was partly because of the backlog of OASys reports, which the prison had decided to prioritise.

2.76 The senior probation officer also did an in-depth evaluation of a small sample of case records each month.

2.77 We considered that the prison had made reasonable progress against this recommendation.

Public protection

Concern: The effectiveness of the inter-departmental risk management team was undermined by an inadequate referral process, which meant it did not routinely review release arrangements for all high-risk prisoners. There was no robust process to ensure that multi-agency public protection arrangements (MAPPA) levels were set in sufficient time to facilitate multi-agency planning for release.

Recommendation: The process to refer prisoners to the interdepartmental risk management team should be improved to ensure that all high risk of harm cases due for release are reviewed regularly. MAPPA levels should be confirmed in time for the prison to be fully involved in multi-agency planning for release. (S45)

2.78 The prison had implemented more robust processes to enhance the public protection function. Each new prisoner arriving was scrutinised by the senior probation officer, as well as by other staff. Case administrators and offender supervisors took effective responsibility for their cases.

2.79 A comprehensive tracking system had been introduced, from each prisoner's arrival. This strengthened assurance that all were referred to the community offender manager for confirmation of the MAPPA management level eight months before release, and to the interdepartmental risk management team (IRMT) meeting at the six-month stage.

2.80 The IRMT meeting was coordinated by the head of the case management team, who decided which cases needed to be discussed, although probation officers and offender supervisors could ask for other cases to be added to this list.

2.81 There were still some delays in the notification of the MAPPA management level by the community offender manager, but there was a well-established escalation process. However,

the senior probation officer had not needed to raise any cases at the highest level externally before notification was received. The escalation process worked, and MAPPA management levels had usually been confirmed by four months before release at the latest.

2.82 We considered that the prison had made good progress against this recommendation.

Section 3. Appendix

Review team

Martin Lomas	Deputy Chief Inspector
Martin Kettle	Team leader
Michael Dunkley	Inspector
Tania Osborne	Health and social care inspector
Fran Russell	Inspector
Emma Sunley	Inspector
Gary Turney	Care Quality Commission inspector
Nick Crombie	Ofsted inspector