Report on an independent review of progress at

HMP Birmingham

by HM Chief Inspector of Prisons

7 – 9 May 2019

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

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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 August 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.

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.

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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 Available at: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-birmingham-3/

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.[3] 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 prison is already having a beneficial impact on learners and improvements are sustainable and are based on the prison's thorough quality assurance procedures.

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

[3] Ofsted's approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook* at paragraphs 25 to 27, available at https://www.gov.uk/government/publications/further-education-and-skills-inspection-handbook

Key findings

S1 At this IRP visit, we followed up nine of the 59 recommendations made at our most recent inspection, Ofsted followed up three themes and we made judgements about the degree of progress achieved to date.

S2 We judged that there was good progress in none of the recommendations, reasonable progress in five recommendations, insufficient progress in three recommendations and no meaningful progress in one recommendation. A summary of the judgements is as follows.

Figure 1: Progress on recommendations from 2018 inspection (n=9)

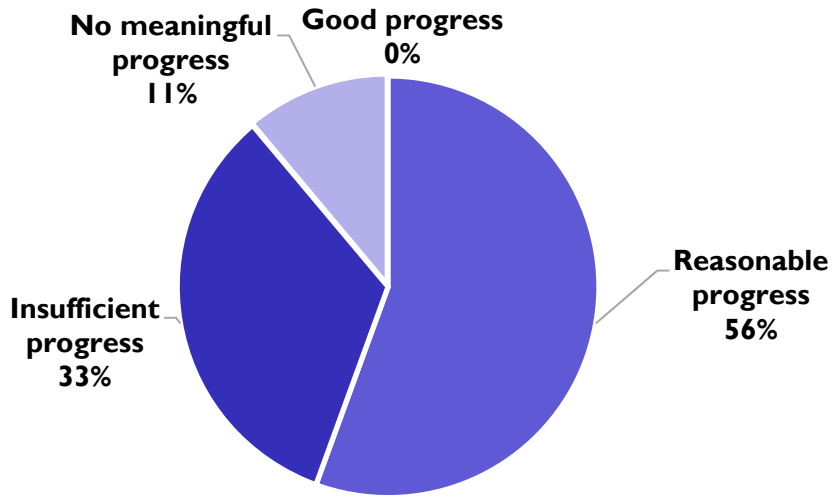


Figure 2: Judgements against HMI Prisons recommendations from August 2018 inspection

Recommendation	Judgement
All steps, including consultation with prisoners, should be taken to understand and analyse the causes of violence and antisocial behaviour. Actions should be taken to reduce violence, and the effectiveness of these should be monitored over time. (S62)	Reasonable progress
Perpetrators of violence and antisocial behaviour should be subject to appropriate administrative or disciplinary actions. (S63)	Insufficient progress
All victims of violence and antisocial behaviour should be identified and assisted with comprehensive support plans which include access to regime activities. (1.18)	Insufficient progress
The prison's drug supply and demand strategy should be further developed, to identify additional practical measures to stop the ingress of drugs and reduce demand more robustly. It should include measures to develop a culture that does not tolerate drug use and actively supports those who are using to stop. (S64)	Reasonable progress
There should be a fundamental improvement in the quality of care for prisoners in distress. Those at risk of self-harm should be properly supported, and triggers such as poor living conditions and isolation	Insufficient progress

should be addressed. The care of those most at risk under assessment, care in custody and teamwork (ACCT) procedures should focus on their assessed needs through a well-managed and effective casework approach. (S65)	
Staff should be effectively supervised, coached and trained to maintain appropriate professional standards and provide a proper balance of care and control. (S66)	Reasonable progress
All prisoners should live in decent, humane conditions. (S67)	Reasonable progress
The prison should implement a strategy to manage and progress sex offenders in order to address their offending behaviour. If they cannot be appropriately progressed, specific and sufficient offending behaviour work should be provided at Birmingham. The skills mix in the offender management unit should be improved, to reflect the need to work effectively with a large high-risk population. (S69)	No meaningful progress
Gaps and weaknesses in public protection arrangements should be identified and urgent remedial action should be taken to protect victims and potential victims. (S70)	Reasonable progress

S3 Ofsted judged that there was reasonable progress in one theme and insufficient progress in two themes.

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

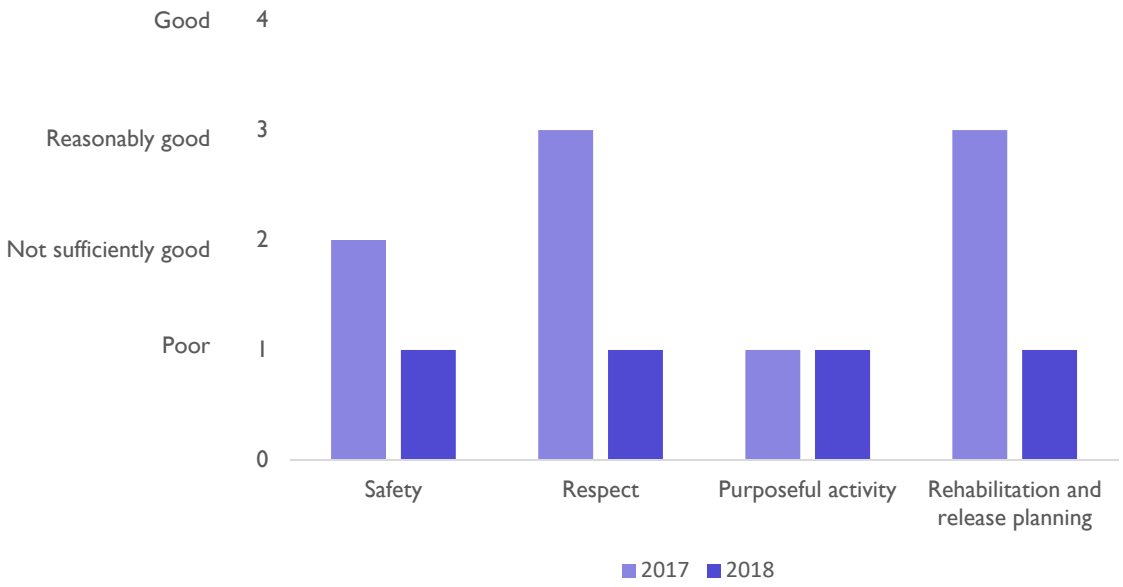
Ofsted theme	Judgement
What progress have leaders and managers made in implementing an education, skills and work provision that meets the prison population's needs and includes the prioritisation of sentenced prisoners' session attendance, English and mathematics development and pre-release preparation, to support their successful resettlement? Addresses previous inspection report recommendations S68. 3.25. 3.29. 3.39. 3.46. 3.47. 3.53	Insufficient progress
What progress have leaders and managers made in introducing comprehensive quality assurance and improvement arrangements so that all prisoners attend a good and rising standard of teaching, learning and assessment leading to high qualification achievement rates and significantly enhanced social, personal, practical and work-related skills? Addresses previous inspection report recommendations 3.26. 3.37. 3.38. 3.41. 3.42. 3.48. 3.52.	Insufficient progress
What progress have leaders and managers made in identifying and addressing fully the needs of prisoners with learning difficulties and/or disabilities, who attend education programmes, so they achieve to an appropriately high level? Addresses previous inspection report recommendation 3.40.	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 Birmingham in August 2018 we made the following judgements about outcomes for prisoners.

Figure 4: HMP Birmingham healthy prison outcomes 2017 and 2018



1.2 HMP Birmingham is a category B local prison serving courts in the country's second largest city as well as other parts of the West Midlands. It is a large, complex and extremely important prison holding adult prisoners ranging from those recently remanded to others serving significant sentences. Historically, it has held around 1,500 prisoners but at the time of this review visit the capacity had been reduced to 977 as three of the large Victorian wings were now considered unfit for habitation and had been closed.

1.3 We last conducted a full inspection of Birmingham in August 2018. At that time, the prison was being run under contract by G4S (who had been in charge for seven years) and we found it to be in an appalling state. Against all four of our healthy prison tests – safety, respect, purposeful activity and rehabilitation and release planning – we assessed outcomes as poor, our lowest assessment. We found a prison that was fundamentally unsafe, where many prisoners and staff lived and worked in fear, where drug taking was barely concealed, delinquency was rife and individuals could behave badly with near impunity. Control in the prison was tenuous, staff were poorly led and many lacked the confidence or the competence to set about retrieving this situation. Many prisoners were living in squalor, little was being done to occupy individuals adequately and the prison was failing in its responsibility to protect the public by preparing prisoners adequately for release. Put simply, the treatment of prisoners and the conditions in which they were held at Birmingham were among the worst we had seen in recent years.

1.4 As a consequence, I decided to invoke the urgent notification (UN) protocol. I made clear that a factor in my decision to invoke the UN was my lack of confidence in the prison to make improvements, the failure of the prison to implement previous recommendations made by this Inspectorate and, perhaps most importantly, I referred to the inertia that seemed to have gripped those responsible for monitoring and managing the contracts and those meant to be delivering action on the ground.

1.5 Shortly after activation of the UN, HMPPS decided to 'step in' and temporarily take over the running of the prison - replacing the G4S director with a public-sector prison governor, reducing the prisoner population, and providing additional public-sector prison staff. In April 2019, the government announced their decision to place the prison under permanent public-sector control and end the G4S contract from July 2019. So, at the time of this review visit, a public-sector prison governor was running the prison, under the G4S contract, which was distracting and inevitably resulted in delays in driving through some improvements.

1.6 At this independent review of progress, we followed up nine recommendations. We found reasonable progress had been made in five of those recommendations, insufficient progress had been made in three and no meaningful progress had been made in one. Working alongside us, Ofsted undertook a monitoring visit, following up three themes in education, skills and work provision. Ofsted found reasonable progress in one theme and insufficient progress in the remaining two.

1.7 The prison had worked exceptionally hard to address violence. The causes of violence were now well understood and a range of actions had been taken to make the prison safer. Levels of violence had decreased since the last inspection but remained considerably higher than the average for similar prisons. Measures had been developed to ensure prisoners faced sanctions for their poor behaviour but, while these measures looked encouraging, they had only recently been introduced and were not yet working effectively. Similarly, considerable efforts had been made to identify victims of violence and bullying, but as yet too little support had been offered. We no longer observed overt drug use on the wings. Although fewer than at our full inspection, one in four prisoners were testing positive for drugs and I found it inexplicable that the prison had been unable to secure funding for equipment such as a body scanner to help them stop drugs entering the prison.

1.8 Work to prevent suicide and self-harm was better resourced and there were some well-developed plans to improve practice, but ACCT[5] procedures were not yet delivered well enough to provide effective care.

1.9 Relationships between staff and prisoners had improved, and the prison felt more ordered and controlled. Staff were more accountable, better supported and more able to establish appropriate boundaries and challenge poor prisoner behaviour. The prison was now much cleaner, prisoners could get hold of basic essentials and living conditions had improved – not least because three of the most squalid wings had been closed. One wing had been fully refurbished but most other wings were in need of similar investment.

1.10 The prison had made reasonable progress in identifying and addressing the needs of prisoners with learning difficulties and/or disabilities. But progress across other areas of education, skills and work was insufficient. The provision did not meet most prisoners' needs – most critically the substantial number of prisoners requiring English and mathematics education. Attendance at activities was low.

1.11 Many of the weaknesses in public protection arrangements had been addressed. The prison had devised a strategy to manage and progress the substantial number of prisoners convicted of sexual offences but, with no support or agreement from across the wider HMPPS, the strategy was unrealistic and likely to fail.

1.12 It is only right that I recognise the scale of the task to improve the treatment and conditions for prisoners at Birmingham. It is huge. There is no doubt that the prison faces a long journey of recovery. It is very clear that the governor, through his vision and very visible leadership, has energised the staff and undoubted pride and optimism are emerging around the prison. I think that optimism is well founded. Birmingham has already made some tangible

[5] Assessment, care in custody and teamwork case management of prisoners at risk of suicide and self-harm.

improvements and has the capacity for further change and improvement if it retains strong leadership and if those responsible for Birmingham at national and regional level provide it with the support necessary to sustain what has begun.

Peter Clarke CVO OBE QPM May 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 and theme followed up from the full inspection in 2018. The reference numbers at the end of each recommendation or theme refer to the paragraph location in the full inspection report.

Managing behaviour

Concern: The number of violent incidents had increased substantially and was higher than at any other local prison. Many prisoners felt unsafe. Incidents were often serious and serious incidents were increasing. There was no consultation with prisoners to explore the reasons for violence, and investigations were rarely completed. This meant that the prison lacked an understanding of the causes of violence that might inform strategic decisions or any supporting action plan.

Recommendation: All steps, including consultation with prisoners, should be taken to understand and analyse the causes of violence and antisocial behaviour. Actions should be taken to reduce violence, and the effectiveness of these should be monitored over time. (S62)

2.1 The prison had responded well to this recommendation and had invested considerable time, effort and resources into understanding and addressing the extremely high levels of violence that we found at the last inspection.

2.2 Levels of violence, including serious assaults, had begun to fall since the last inspection and the prison was no longer the most violent local prison in England and Wales. Despite this improvement, levels remained much higher than the average for this type of prison.

2.3 The safer custody team was now better resourced and there was a comprehensive and well-considered strategy setting out the prison's approach to reducing violence. A good range of initiatives had been implemented to reduce violence. There was, however, no supporting action plan to map out actions and measure progress and the effectiveness of the actions which had been taken.

2.4 Understanding of the causes of violence was good and was underpinned by extensive and routine analysis and widespread consultation with prisoners and staff. There were regular local forums and more formal events were organised in conjunction with community agencies.

2.5 There was an effective and dynamic response to emerging issues. Violent incidents were all recorded. A daily briefing to staff, usually delivered by the governor, delivered up-to-date analysis including hotspots of poor behaviour and emerging trends. Immediate actions were identified and allocated to staff. A weekly stability meeting then consolidated the issues identified throughout the week and provided the prison with a well-informed overview.

2.6 In January 2019, the prison had introduced challenge, support and intervention plans (CSIP) to manage perpetrators. We were satisfied that all incidents of violence were now routinely investigated within 72 hours. However, although some perpetrators were being placed on CSIP, there was little evidence that these plans resulted in tangible actions and wing staff were generally unable to identify prisoners subject to CSIP.

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

Concern: Prisoners rarely faced any sanctions when they committed violent acts or were involved in antisocial behaviour, fostering a culture of near impunity.

Recommendation: Perpetrators of violence and antisocial behaviour should be subject to appropriate administrative or disciplinary actions. (S63)

2.8 The prison had very recently introduced a new incentives and earned privileges (IEP) scheme. Case notes showed that sanctions were not applied consistently and reviews of prisoners' behaviour were not always completed. Neither staff nor prisoners we spoke to were yet familiar with the scheme. During our visit, we found prisoners placed on the basic regime who had not received any paperwork explaining the decision and who were still in possession of their television, a privilege which was supposed to be removed. They were unaware of their behaviour targets or the date of their next review.

2.9 Measures to improve and monitor adjudication processes had been recently introduced. The frequency of the adjudication standardisation meeting had increased to once a month to address deficiencies. Officers now attended the segregation unit to complete their documentation alongside a member of staff trained in adjudication to improve the likelihood of a correct outcome. The security department now met the police in a weekly crime clinic to discuss outstanding referrals. The number of adjudications which were dismissed had reduced significantly since the start of 2019, but too many adjudications were adjourned, and those referred to the police were still subject to long delays.

2.10 Although the safer custody department had a good understanding of the CSIP process, wing staff we spoke to could not describe the next steps after a referral had been made. They were unable to tell us which prisoners were currently subject to a CSIP. Individual plans that we looked at were weak with generic targets. Prisoners were not always aware of their targets and did not yet understand the process.

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

Concern: Numerous prisoners on general wings were living in self-isolation. These prisoners were often unknown to the safer custody team and were entirely unsupported, with no regime or managerial oversight. In addition, some prisoners, despite being located on vulnerable prisoner wings, experienced continuing harassment and victimisation from other prisoners and there was often inadequate staff presence to deter antisocial behaviour and prevent or deal with bullying, victimisation and violence.

Recommendation: All victims of violence and antisocial behaviour should be identified and assisted with comprehensive support plans which include access to regime activities. (1.18)

2.12 The renewed focus on violence and improved recording systems meant that most victims of violence and antisocial behaviour were now quickly identified. Management checks on a wide range of data and records had brought about an increase in the accuracy of reporting, so the safer custody department had more up-to-date information.

2.13 However, we were concerned by persistent reports of the victimisation and bullying of prisoners convicted of sexual offences who lived on N wing (one of the vulnerable prisoner wings, which held a mix of prisoners convicted of sexual offences and other prisoners seeking sanctuary). We did not see any evidence that these concerns were being addressed.

2.14 The previously high number of prisoners electing to self-isolate in their cells had reduced considerably and managers were now aware of who and where they were. There was a new policy to manage these prisoners, but few wing staff were aware of the new processes and the regime and care afforded to these prisoners remained inadequate. Case notes that we checked failed to assure us that these self-isolating prisoners routinely received even the most basic elements of a daily regime.

2.15 There was little evidence of any support for victims, and no CSIPs were in place for any victims of violence.

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

Security

Concern: Drugs were easily available. Half the population said that it was easy to get illicit drugs at the prison, and one in seven that they had developed a drug problem while there. We witnessed many prisoners openly using and under the influence of drugs around the site. A cluster of three deaths earlier in the year were potentially linked to the abuse of drugs. Strategic efforts were undermined by an almost widespread ambivalence by staff to challenging drug use on the wings.

Recommendation: The prison's drug supply and demand strategy should be further developed, to identify more robustly additional practical measures to stop the ingress of drugs and reduce demand. It should include measures to develop a culture that does not tolerate drug use and actively supports those who are using to stop. (S64)

2.17 Positive mandatory drug testing rates had fallen since the last inspection from around 33% to just under 24% which was marginally above the average for this type of prison. The positive testing rate for new psychoactive substances (NPS)[6] had also fallen with about six prisoners testing positive each month compared to 12 at the last inspection.

2.18 A new and much improved drug and alcohol strategy had been introduced shortly before our visit. There was a good focus on supply reduction and robust action had been taken to address and try to deter staff corruption. The strategy had also been published in smaller 'workplace relevant' quick-read booklets that outlined specific measures for individual areas of the prison to undertake to implement the overall strategy.

2.19 A good range of actions had been implemented, including the formation of a dedicated team of well-trained staff to conduct suspicion-based searching, the deployment of drug detection dogs and additional internal patrols. The need for electronic body scanners to identify contraband concealed by prisoners on entry to the prison and additional mail scanning equipment to detect letters impregnated with illegal substances had been identified. However, to date the prison's bids for funding for this equipment had been unsuccessful.

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6 NPS 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 vapourised and inhaled in e-cigarettes and other devices.

2.20 Treatment and support options to reduce the demand for drugs were still too limited and the role of the newly opened 'drug-free' wing as yet provided little in the way of interventions or support.

2.21 We no longer observed the overt, unchallenged drug use that was so prevalent across the prison at the last inspection. The almost universal smell of cannabis and other burning substances was no longer evident. We were satisfied that the drive to change the staff culture, including the routine challenge of poor behaviour by prisoners and use of staff's legitimate authority, was developing well (see paragraph 2.32).

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

Safeguarding

Concern: Care for prisoners in crisis and at risk of self-harm was poor. Too often their needs were ignored, and many lived in squalid conditions, locked in their cells for long periods and with no access to activities. ACCT procedures to meet the needs of those most at risk were poorly managed and ineffective.

Recommendation: There should be a fundamental improvement in the quality of care for prisoners in distress. Those at risk of self-harm should be properly supported, and triggers such as poor living conditions and isolation should be addressed. The care of those most at risk under ACCT procedures should focus on their assessed needs through a well-managed and effective casework approach. (S65)

2.23 Recorded levels of self-harm were higher than at the last inspection. There had been 346 incidents in the six months to the end of March 2019, against 239 incidents in the six months before the last inspection. Current levels were similar to other local prisons. There had been no self-inflicted deaths since the last inspection.

2.24 Work to prevent suicide and self-harm was now much better resourced. The previously unmanageable workload of the head of safety had been reduced. Her team was larger and now included four safer custody officers with specific responsibility for suicide and self-harm prevention.

2.25 A realistic plan to deliver suicide and self-harm prevention training to staff was well under way and due to continue throughout 2019. Two-thirds of officers had received this training. A mental health first aid course was being rolled out. Virtually all ACCT case managers and a third of ACCT assessors had been trained since our last inspection.

2.26 ACCT case managers had recently started to receive supervision to improve their practice. Since late March 2019, four group supervision sessions had been held, and managers had just started holding individual meetings with case managers to address gaps in practice.

2.27 The quality of ACCT casework was not yet good enough. In response to our concern at the last inspection, managers had sought to deliver single case management and provide prisoners in crisis with activities. This ambition had not yet been realised. None of the eight cases we checked had a single case manager. Only one of the eight had successfully accessed work or education as a result of the ACCT process.

2.28 At the last inspection, we were concerned about prisoners in crisis being held in squalid conditions. Living conditions had improved but there was more work to be done (see paragraph 2.36).

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

Staff-prisoner relationships

Concern: Staff–prisoner relationships had deteriorated markedly and were a major concern. Some wings were very poorly supervised and some prisoners routinely disregarded rules and appropriate standards of behaviour. Some vulnerable prisoners were openly bullied, with staff failing to take action.

Recommendation: Staff should be effectively supervised, coached and trained to maintain appropriate professional standards and provide a proper balance of care and control. (S66)

2.30 Since the last inspection, as part of the 'step-in' process, about 30 members of staff from public sector prisons, including managers, had been brought in to work alongside G4S staff.

2.31 Managers were now all working under clear direction with regular bilateral meetings to review their performance. They were more visible on the wings and attended at key times, for example mealtimes and association, to support wing staff. A daily briefing from the governor provided valued leadership and guidance and helped to instil confidence in staff.

2.32 Nearly all staff and prisoners we spoke to said that they felt safer and relationships had improved. Some staff we spoke to were proud to work at the prison and spoke positively of the direction they were now following. Prisoners who had been at the prison since the last inspection were keen to tell us how the prison had improved.

2.33 Staff supervision of prisoners had improved and the new core day and regime allowed more control of the wings. More staff were detailed across the wings. Staff were aware of prisoners' locations, for example if they had gone to work. Potentially challenging periods, such as supervising the meal queues and locking up prisoners, were much more ordered.

2.34 We observed mainly positive staff interactions with prisoners, including the appropriate challenge of prisoners and setting of boundaries. However, this was inconsistent and we came across some instances where prisoners were not appropriately challenged, did not face sanctions or were not appropriately cared for.

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

Living conditions

Concern: Living conditions were very poor, and some of the worst we have seen.

Recommendation: All prisoners should live in decent, humane conditions. (S67)

2.36 Since the last inspection, A, B and C wings, the three largest of the older Victorian residential units and the most squalid, had been closed. The prison now held just under 1,000 prisoners, about a third less than when we last inspected.

2.37 Another of the older residential units, G wing, had been refurbished and now offered decent living conditions, including private in-cell toilets and good quality communal showers.

2.38 Substantial improvements had been made to the cleanliness of all other wings. We no longer saw rubbish piled up in communal areas, we saw prisoners cleaning regularly and most cells had been repainted. An activities, basics and cleanliness (ABC) strategy had been implemented with management checks in place, including daily inspections. Managers had introduced a 'decency tracker' to identify cells which required improvement. However, too many cells still needed refurbishment and maintenance, for example most toilets were still without seats or covers and were not screened in shared cells. Some cells did not have tables for prisoners to eat their meals. Although cleaner, cells were still shabby and stained. Some communal showers were out of order.

2.39 Prisoners had access to basic equipment and could change their clothing and bedding weekly, although on one wing there were not enough towels and some clothing was damaged. A full stock of cleaning materials was available to prisoners.

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

Education, skills and work

Theme 1: What progress have leaders and managers made in implementing education, skills and work provision that meets the population's needs and includes the prioritisation of sentenced prisoners' attendance at sessions, English and mathematics development and pre-release preparation, to support their successful resettlement?

2.41 At the last inspection, the learning and skills provision failed to contribute sufficiently to the development of prisoners and their successful rehabilitation. Most prisoners had no access to learning which recognised their attainment and supported their resettlement. The importance of raising prisoners' English and mathematics competence levels was poorly addressed. Attendance at education, skills and work activities was very low.

2.42 During this visit, we found that provision still did not adequately meet the needs of the population. Suitable progression routes, linked to prisoners' career aspirations and resettlement, were not available. The range and variety of programmes offered to prisoners capable of high achievement and those serving short sentences required further improvement. The quantity and variety of accredited programmes in workshops had not improved. The newly appointed head of learning and skills had designed a revised curriculum which was appropriately informed by the recently completed needs analysis of prisoners' skills development needs. The full introduction of the curriculum was expected within the coming months.

2.43 Overall, sentenced prisoners' attendance at sessions had improved but was still low and particularly so in education. The practice of prisoners attending recreational sport and gym activities during the core day had ceased. Prisoners could self-elect to leave education to go to the library. This disrupted classes and slowed prisoners' progress in completing tasks.

2.44 Leaders and managers had not prioritised adequately the development of prisoners' English and mathematics skills. Too few prisoners improved their skill levels in these subjects. Qualification achievement rates had risen but were low, particularly for English at level 2. In the production workshops, the laundry and during wing work, prisoners did not receive effective support to improve their skill levels.

2.45 Leaders and managers had been slow to ensure that prisoners received sufficient preparation before release and the available arrangements were too limited in scope. Attendance was low and poorly monitored. Only vulnerable prisoners living on N and P wings could use the virtual campus[7] to undertake searches that facilitated their resettlement.

2.46 We considered the prison had made insufficient progress against this theme

Theme 2: What progress have leaders and managers made in introducing comprehensive quality assurance and improvement arrangements so that all prisoners attend a good and rising standard of teaching, learning and assessment leading to high qualification achievement rates and significantly enhanced social, personal, practical and work-related skills?

2.47 At the last inspection, prison managers had not implemented effective quality assurance measures for the whole of the education, skills and work provision. They did not have an accurate appreciation of the strengths and weaknesses of provision. The education and vocational training delivered by the college was inadequate.

2.48 During this visit we found that, with the exception of the relatively limited education and vocational training provision, the majority of activities were not subject to effective quality monitoring. The quality of workshop and work activities, in which a high proportion of prisoners participated, had not significantly improved since the last inspection. The number of wing workers had been reduced but many were still underemployed. Leaders and managers had made little progress in introducing actions to promote and recognise prisoners' social, personal, practical and work-related skills.

2.49 The newly appointed head of learning and skills had developed suitable quality assurance processes designed to improve the whole provision. The proposed arrangements were comprehensive and detailed but had not yet been implemented.

2.50 College managers had effectively improved the education and vocational training provision. Managers had used the results of session observations and prisoner feedback to plan an intensive programme of staff development and coaching. The quality and improvement of provision was effectively monitored at monthly performance meetings, chaired by the governor. These developments, alongside robust performance management of tutors, had improved the quality of education and vocational training. Achievement rates had also improved, though they were still low in too many subjects.

2.51 We considered the prison had made insufficient progress against this theme.

Theme 3: What progress have leaders and managers made in identifying and addressing fully the needs of prisoners with learning difficulties and/or disabilities, who attend education programmes, so they achieve to an appropriately high level?

2.52 At the last inspection the identification of prisoners with learning difficulties or disabilities was weak, and there was not enough provision to support these prisoners.

2.53 At this visit, we found that the appointment of a specialist tutor had led to more effective assessment and help for prisoners with additional support needs. Tutors had participated in training to identify quickly prisoners with a learning difficulty or disability. Consequently, prisoners received appropriate help at a suitably early stage of their course.

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[7] prisoner access to community education, training and employment opportunities via the internet

2.54 The specialist tutor completed a detailed evaluation of prisoners' barriers to learning. This analysis was used well to generate a course-specific learning plan for each prisoner. The plan set out the difficulties prisoners might face and the strategies that tutors could use to provide effective support. Tutors routinely reviewed the plans to improve their effectiveness and incorporated these improvements into their lesson plans appropriately. As a result, learners received good support that helped them attain at an appropriate rate. Their qualification results were similar to those of prisoners who did not have additional needs. A further specialist tutor had been recruited to cope with demand but had not yet started work.

2.55 We considered the prison had made reasonable progress against this theme.

Rehabilitation and release planning

Concern: The number of sex offenders had doubled since the previous inspection and about a quarter of the total population was now assessed as presenting a high risk of harm to others. The prison had not developed a strategy to manage these prisoners. For example, there were no offending behaviour interventions to challenge sex offenders and many were stuck at the establishment with little prospect of progression and few opportunities to reduce their risk. Uniformed offender supervisors lacked the skills and confidence to manage and progress the sex offenders on their caseloads, and levels of contact were poor.

Recommendation: The prison should implement a strategy to manage and progress sex offenders in order to address their offending behaviour. If they cannot be appropriately progressed, specific and sufficient offending behaviour work should be provided at Birmingham. The skills mix in the offender management unit should be improved, to reflect the need to work effectively with a large, high-risk population. (S69)

2.56 The prison continued to hold a large number of prisoners convicted of sexual offences. About 60% were assessed as a high risk of harm. There were still no treatment programmes for them at Birmingham and no plans to introduce any.

2.57 The offender management unit (OMU) did not yet have a sufficiently skilled staff group to complete one-to-one work with these prisoners. Only three probation officers had an adequate skills base, but there were solid plans to upskill three uniformed offender supervisors in the near future.

2.58 The prison had been assisted by the local psychology team to analyse prisoners convicted of sexual offences and develop a strategy for them, which had just been published. The intention was to progress prisoners to other establishments. So far, less than half these prisoners had an up-to-date Risk Matrix 2000 assessment to inform their treatment pathway, but additional staff had just been trained to use this assessment tool.

2.59 The OMU had recently started to hold boards to identify prisoners convicted of sexual offences who were suitable for an accredited programme. They had also started to contact prisons offering the necessary accredited programmes to seek a transfer for some of these identified prisoners. However, Birmingham was still required to sustain a population of prisoners convicted of sexual offences, and the strategy would only succeed if these establishments returned prisoners who had completed treatment to Birmingham. With no support at national level, this strategy was unrealistic and, although it was early days, so far nobody had transferred to a treatment site as a result of the boards held since March 2019.

2.60 We considered that the prison had made no meaningful progress against this recommendation.

Concern: Basic public protection arrangements were very poor and potentially exposed victims to further contact from perpetrators. Telephone monitoring had become unmanageable, with calls routinely not listened to for several months, so risks were not promptly identified. Some mail monitoring was being carried out but without proper authority. Staff who booked visits were not informed of all prisoners with child contact restrictions.

Recommendation: Gaps and weaknesses in public protection arrangements should be identified and urgent remedial action should be taken to protect victims and potential victims. (S70)

2.61 Resources to conduct mail and telephone monitoring had been increased. A group of 10 operational support grade staff were now assisting with these tasks but so far nobody had been trained to support the two existing PIN phone monitoring clerks.

2.62 At the time of our visit, 46 prisoners were subject to telephone monitoring, which was manageable and much less than at the last inspection. The initial period of monitoring had been reduced from a month to two weeks to achieve this, and better use was made of the initial authorisation process to ensure that only relevant cases were monitored. Monitoring logs that we checked were up to date and reviews, now allocated to the relevant offender supervisor, were timely. However, the interpreting of foreign language calls was still not routine and it was not always possible to identify live risk.

2.63 Mail room staff now only read incoming and outgoing mail for prisoners who were subject to monitoring.

2.64 Procedures to set and enforce child contact restrictions were improving but needed more robust oversight. We checked the records of 10 prisoners who were not supposed to have contact with children. In nine cases, the correct alerts had been shared with staff booking social visits, but in one case there was no alert to prevent possible contact with a child. The OMU did not yet have a process for assessing the continuing risk a prisoner posed to children and reviewing this annually. We were not, therefore, confident that all the restrictions in place were appropriate.

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

Section 3. Appendix

Review team

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