HM INSPECTORATE OF PRISONS



3rd floor 10 South Colonnade Canary Wharf London E14 4PU

E-mail: barbara.buchanan@hmiprisons.gov.uk

HM Chief Inspector of Prisons CHARLIE TAYLOR

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Rt Hon Robert Buckland QC MP Lord Chancellor and Secretary of State for Justice Ministry of Justice 9th floor, 102 Petty France London SW1H 9AJ

Dear Secretary of State

Urgent Notification: HMP & YOI Chelmsford

Summary

In accordance with the Protocol between HM Chief Inspector of Prisons and the Ministry of Justice (MoJ), I am writing to you to invoke the Urgent Notification (UN) process in respect of HMP & YOI Chelmsford.

An unannounced inspection of the prison between 9 and 20 August 2021 identified numerous significant concerns about the treatment of and conditions for prisoners. This is the most recent in a series of concerning inspections over the last seven years and these findings were particularly disappointing bearing in mind the observations my predecessor made in 2018. At that time, the then Chief Inspector decided against instigating the UN protocol, having been persuaded that the prison had already begun to show signs of improvement under a new governor and with the support of HMPPS. This latest inspection showed that these improvements have not materialised.

As required by the process, I will set out in this letter the key evidence underpinning my decision to invoke the UN protocol. In addition, I attach a summary note with the main judgements from this inspection drawn from a similar document provided to the Governor at the end of the inspection last week. The Governor, the Prison Group Director and Ministry of Justice officials have been informed of my intention to invoke the UN process. I shall, as usual, publish a full inspection report in due course.

What the UN process requires of HM Chief Inspector of Prisons

A decision to invoke the UN process is determined by my judgement, informed by relevant factors during the inspection that, as set out in the protocol between HM Chief Inspector and the MoJ, may include:

- poor healthy prison test assessments (HMI Prisons' inspection methodology is outlined in the HMI Prisons Inspection Framework);
- the pattern of the healthy prison test judgements;
- repeated poor assessments;
- the type of prison and the risks presented;
- the vulnerability of those detained;
- the failure to achieve recommendations;
- the Inspectorate's confidence in the prison's capacity for change and improvement.

The protocol sets out that this letter will be placed in the public domain, and that the Secretary of State commits to respond publicly to the concerns raised within 28 calendar days. The response will explain how outcomes for prisoners in the institution will be improved in both the immediate and longer term.

Inspections of HMP Chelmsford since 2014

We last inspected Chelmsford prison in June 2018, when we reported our continued concerns at the deterioration of treatment and conditions. This followed our inspection in 2016 where we found that progress had stalled. In 2018 outcomes in safety and the provision of purposeful activity were found to be poor and outcomes in respect were assessed as being not sufficiently good. Only in rehabilitation and release planning did we judge outcomes to be reasonably good. At the time, however, and although a UN was given serious consideration, it was thought there may be grounds for some cautious optimism. The then Chief Inspector was reassured by both local management and HMPPS that they were sighted on the problems at the prison and a strategy was in place. In the 2018 report, my predecessor concluded his introduction as follows:

"As long as the leadership of the prison remains consistent, and vital regional-level HM Prison and Probation Service (HMPPS) support continues, there is no reason why the very serious problems afflicting the prison cannot be addressed. Leadership at both local and regional level readily acknowledged the gravity of the issues facing the jail, and HMPPS had already placed the prison in 'special measures'. I therefore concluded that on this occasion I had sufficient confidence in the ability of the prison to improve that I would not invoke the Urgent Notification protocol. To help prison managers to address the key issues that caused us most concern, I have decided on this occasion to make only a small number of relatively high level main recommendations and am hopeful that, if progress can be made in these areas, we will find the prison much improved on our next visit."

At the latest inspection, in August 2021, we found that the optimism that had been expressed three years ago was misplaced. In coming to these judgements, I took full account of the context of the last 18 months and the challenges of the COVID-19

pandemic. Chelmsford, like nearly all other prisons, has been hit hard by the virus, but the failings we have identified are deep set. In addition, we were told at the 2018 inspection that HMPPS had in place a 'special measures' plan of intervention for Chelmsford. This programme had, however, proven to be largely ineffective in improving outcomes. At the latest inspection we were told that in the autumn of 2020 HMPPS had recognised the need to provide further support to Chelmsford by introducing a Prison Performance Support Plan (PPSP), although one year on this had barely begun. A new governor had recently been appointed and we were encouraged by his vision and enthusiasm, but it was too early to confirm any real improvements and it was clear to us that he and his team will need significant, ongoing support.

The chronic and apparently intractable failings at Chelmsford have now been evident for at least a decade, with our inspection in 2011 being the last time we felt able to report positively on the prison. It has sadly failed in its responsibility to keep prisoners safe. We have now assessed outcomes in safety as poor for two consecutive inspections, and not sufficiently good for the two inspections prior to that. The prison's record in providing purposeful activity, including training and education that may equip prisoners to lead productive lives on release, is equally poor and the prison's performance in ensuring a measure of respectful treatment is still not good enough. Even rehabilitation and release planning, a former strength, has deteriorated. Of nine main recommendations we made three years ago, none has been fully achieved. These factors, combined with the inherent risks and vulnerabilities associated with Chelmsford's status as a frontline local establishment, mean the prison meets all our criteria for an Urgent Notification.

Key findings from this inspection

- A dominant staff culture, that is negative and damaging, has led to the failure to promote safety, decency or rehabilitation among prisoners. Although a few staff members we spoke to were committed and constructive, many others described very low morale, disillusionment and disengagement. Staff members often failed to respond to even basic requests from prisoners and too many were dismissive and showed only limited empathy and care for those for whom they were responsible. Prisoners experienced real frustration in getting anything done, with leaders suggesting to us that the rise in assaults on staff was a direct result of these issues. In our survey, significantly fewer prisoners than in 2018 reported that staff treated them with respect or that they had somebody to turn to for help and some were even more negative in their views. Almost half of the prisoners in our survey said that they had been victimised by staff, particularly those with disabilities and mental health problems. Nearly a third of staff had under two years' experience, but they had yet to receive adequate mentoring or support.
- Lack of accountability and management oversight of staff enabled poor performance and behaviour to go unchallenged. Many staff had witnessed unacceptable behaviour among their peers and too few took responsibility for the duties to which they had been deployed. Applications were not followed up and prisoners struggled to get staff to provide the basics, such as bedding or pillows. Prisoners were not sure when they would be unlocked as the core day was not published. Often, first night cells approved for occupation by managers were

clearly not fit for purpose. Emergency cell bells were often only answered after long delays.

- At our 2018 inspection we raised serious concerns about the prison's work to prevent suicide or self-harm. Despite our recommendations and the subsequent intervention of the Prisons and Probation Ombudsman, outcomes had deteriorated. Eight self-inflicted deaths and four non-natural deaths had occurred since our last inspection; this is also the fourth consecutive inspection where we have reported increases in the rate of self-harm. We found many weaknesses in the assessment, care in custody and teamwork (ACCT) and other preventative processes, failings in night safety procedures and a lacklustre approach to the use of data and action planning.
- Over a quarter of prisoners said that they felt unsafe at the time of this inspection and more than half had felt unsafe at some point during their stay at Chelmsford. Violence levels since 2018 remained among the highest of all local prisons. Analysis of data was poor, preventing a deeper understanding of risks, so it was not surprising that plans to tackle violence and improve outcomes were limited or non-existent. The lack of accountability we referred to earlier manifested itself in an over-reliance on the small safer custody team, whose work was given insufficient priority, and in failure of other staff members and senior leaders to take responsibility.
- At this inspection we found many prisoners locked in their cell for almost 23 hours a day. This reflected the COVID-19 restrictions, but even in 2018 many prisoners were locked in their cell for 22 hours a day. Some restoration of education had recently begun, providing some additional activity, but a third of these places were unused. Plans to reintroduce a meaningful regime were limited and being implemented far too slowly.

HMP & YOI Chelmsford is a violent, unsafe prison in which conditions for prisoners have declined disturbingly over recent years, despite attempts by HMPPS to support improvement. Many failings stem from a negative and demoralised staff culture which results in little apparent concern for (or attention to) the welfare and basic needs of a complex and, at times, vulnerable population. Chelmsford will not improve without a sustained drive to make sure that all staff members take responsibility for ensuring safety, decency and engagement with training and education in a meaningful regime. This will require strong, consistent leadership at all levels within the prison and much more effective support from HMPPS than the approach it has taken in recent years, which failed completely to arrest the drift and decline which must have been obvious to the service.

Yours sincerely

Chliff

CHARLIE TAYLOR