Report on an unannounced inspection of

HMP & YOI Chelmsford

by HM Chief Inspector of Prisons

9–21 August 2021

Contents

Introduction

HMP Chelmsford is a category B local and resettlement prison for adult and young adult men. At the time of this inspection 712 prisoners were held in a sprawling institution, comprising older wings from the Victorian era and more modern facilities added from the late 1990s.

Following this inspection, I wrote to the Secretary of State on 26 August 2021 invoking the Urgent Notification (UN) protocol (see Appendix IV: Further resources). I set out in detail my concerns about the prison and the judgements that had caused our course of action. Under the protocol, the Secretary of State commits to respond publicly to the UN within 28 days, explaining how outcomes for those detained will be improved. The Secretary of State's response, for which I am grateful, is also detailed in the further resources for this report (see Appendix IV).

We had last inspected Chelmsford prison in June 2018 and reported our serious concerns about the conditions we found. At that time, we assessed outcomes in safety and purposeful activity as poor, our lowest assessment, and in respect, not sufficiently good. Only in rehabilitation and release planning did we judge outcomes to be reasonably good. Despite this, the then Chief Inspector was reassured by both local management and HM Prison and Probation Service (HMPPS) that they were aware of the problems at the prison and would implement strategies for improvement. Sadly, that optimism was misplaced. At this inspection we found no improvement in outcomes in safety and purposeful activity, both of which remained poor; no improvement in respect where outcomes remained not sufficiently good, and a deterioration in rehabilitation and release planning to not sufficiently good. In reaching these judgements I took full account of the additional pressures placed on the prison due to the COVID-19 pandemic, but also the failure of the special measures programme and other initiatives introduced by HMPPS to drive improvement. These had not worked.

As at our last inspection in 2018, a new governor had been appointed a few months before we arrived. We were encouraged by his vision and enthusiasm for the establishment, but we were also struck by the seeming intractability of the failings at Chelmsford. The last time we were able to write a positive report about this prison was 10 years ago and it was clear to us that the jail was failing in its basic duty to keep those it held safe. This report also highlights our concern about the negative and damaging staff culture. Many staff were new or inexperienced, their morale was low and they were disengaged from their work and dismissive of the men in their care. Prisoners found it very difficult to access even the most basic entitlements and were frustrated that they could not get things done. We were told that this frustration had led to an increase in assaults on staff.

The negative culture among some staff was compounded by a lack of management oversight or accountability, which allowed poor staff behaviour and practice to go unchallenged. Other very serious concerns included the inadequacy of the prison's response to the high levels of suicide and self-harm,

and the similarly deficient response to some of the highest levels of violence in the prison estate. The paucity of the daily regime meant that many prisoners spent extended periods locked up and isolated in their cells. It was no surprise that many prisoners told us that they felt unsafe at the prison.

Such factors, combined with the inherent risks and vulnerabilities associated with Chelmsford's status as a frontline local establishment and the failure to grip the prison's problems over recent years, meant that Chelmsford met our criteria for an Urgent Notification. I concluded my letter to the Secretary of State by saying that HMP Chelmsford would not improve without a sustained drive to make sure that all staff members take responsibility for creating a safer, more decent environment, a meaningful regime and greater engagement with training and education. I argued that this will require strong and consistent leadership at all levels within the prison and much more effective support from HMPPS. As we indicated in 2018 and repeat now, the drift and decline at this prison must be addressed.

Charlie Taylor
HM Chief Inspector of Prisons
September 2021

About HMP & YOI Chelmsford

Task of the prison/establishment
A category B local reception and resettlement prison holding adult men and a small number of young adults.

Certified normal accommodation and operational capacity (see Glossary of terms)
Prisoners held at the time of inspection: 712
Baseline certified normal capacity: 550
In-use certified normal capacity: 550
Operational capacity: 720

Population of the prison
- Over 200 new prisoners arrived and an average of 83 prisoners were released each month.
- The proportion of unsentenced prisoners had increased to almost 60%.
- A quarter of prisoners were from black and minority ethnic backgrounds.
- The prison held 96 foreign national prisoners.
- 10% of the population were aged under 21.
- 125 prisoners were receiving antipsychotic medication and there was a high level of mental health need.
- 41% of the population received care from the substance misuse psychosocial team.

Prison status (public or private) and key providers
Public

Physical health and mental health provider: Castle Rock Group Medical Services Limited
Substance misuse treatment provider: Forward Trust
Prison education framework provider: PeoplePlus
Escort contractor: Serco

Prison group
Hertfordshire, Essex and Suffolk

Brief history
HMP and YOI Chelmsford was built in the 1830s. E and F residential units were added in 1996 and G wing was opened in 2006. The prison serves local courts and holds those who are sentenced or on remand.

Short description of residential units
Old Victorian-built wings
A wing – includes segregation unit
B wing – includes reverse cohort and induction units
C wing – general population
D wing – general population
Newer wings
E wing – drug interventions unit

F wing – general population
G wing – vulnerable prisoners on one side and enhanced prisoners on the other side.
Enhanced care unit – 12 beds for unwell prisoners, including those with mental health needs. Heath care staff attend the unit as needed to provide care for prisoners.

Name of governor and date in post
Garry Newnes, 26 April 2021

Leadership changes since the last inspection
Penny Bartlett, 21 May 2018 – 25 April 2021

Prison Group Director
Simon Cartwright

Independent Monitoring Board chair
Martin Burchett

Date of last inspection
21 May 2018 – 7 June 2018

Section 1 Summary of key findings

1.1 We last inspected Chelmsford in 2018 and made 10 recommendations, all of which were about areas of key concern. The prison fully accepted six of the recommendations and partially (or subject to resources) accepted three. It rejected one of the recommendations.

1.2 Section 8 contains a full list of recommendations made at the last full inspection and the progress against them.

Progress on key concerns and recommendations from the full inspection

1.3 Our last inspection of Chelmsford took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for prisoners at the time. Although we recognise that the challenges of keeping prisoners safe during COVID-19 will have changed the focus for many prison leaders, we believe that it is important to report on progress in areas of key concern to help leaders to continue to drive improvement.

1.4 At our last full inspection, we made three recommendations about key concerns in the area of safety. At this inspection we found that one of these recommendations had been partially achieved and two had not been achieved.

1.5 We made three recommendations about key concerns in the area of respect. At this inspection we found that one recommendation had been partially achieved and two had not been achieved.

1.6 We made three recommendations about key concerns in the area of purposeful activity. At this inspection we found that two recommendations had not been achieved. Ofsted carried out a progress monitoring visit alongside our inspection to assess the progress that leaders and managers had made towards reinstating a full education, skills and work curriculum. They judged it was too early to assess whether one recommendation made at the last inspection had been achieved.

1.7 We made one recommendation about key concerns in the area of rehabilitation and release planning. At this inspection we found that this recommendation had not been achieved.

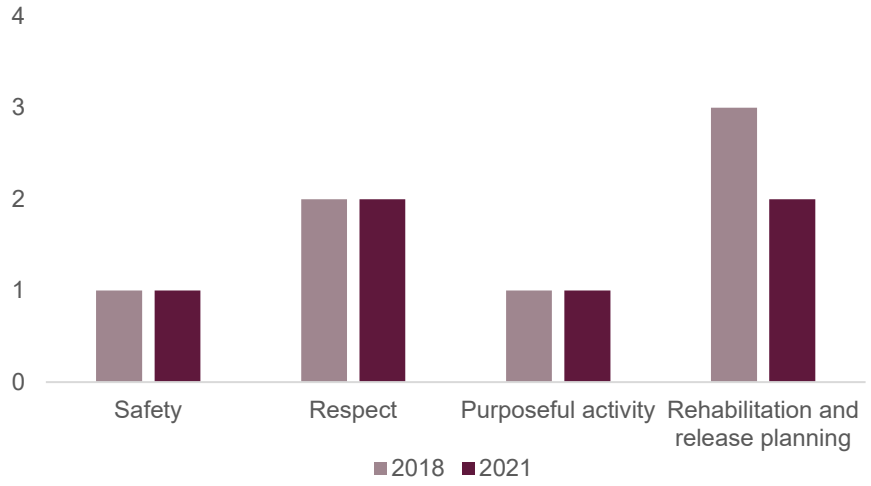
Outcomes for prisoners

1.8 We assess outcomes for prisoners against four healthy prison tests (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.9 At this inspection of Chelmsford, we found that outcomes for prisoners had stayed the same in three healthy prison areas and declined in one.

1.10 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account the prison's recovery from COVID-19 as well as the 'regime stage' at which the prison was operating, as outlined in the HM Prison and Probation (HMPPS) National Framework for prison regimes and services.

Figure 1: HMP&YOI Chelmsford healthy prison outcomes 2018 and 2021



Safety

At the last inspection of Chelmsford in 2018 we found that outcomes for prisoners were poor against this healthy prison test.

At this inspection we found that outcomes for prisoners remained poor.

1.11 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 remained high, with the number of incidents still among the highest for all local prisons. Almost half the prisoners in our survey said that they had been victimised by staff, and responses among those with disabilities and mental health problems were even worse. Analysis of data related to safety issues was weak and plans to improve outcomes often had only limited impact, if they existed at all. The safer custody team was not properly resourced, the behaviour of violent prisoners was not challenged and victims lacked support.

1.12 There had been eight self-inflicted deaths and four non-natural deaths since 2018. The number of self-harm incidents had increased significantly yet again, a pattern we have now reported consistently over our four most recent inspections. Staff lacked confidence in using the new assessment, care in custody and teamwork (ACCT) case management document for at-risk prisoners, and some prisoners we spoke to felt they lacked support. The strategic approach to reducing self-harm was limited and there had, for example, been no detailed analysis of data to understand the risks and priorities for the prison.

During our night visit we observed serious flaws in safety practice. Despite serious failings identified by the Prisons and Probation Ombudsman (PPO) and others, the prison had not achieved fully any of our key concerns and recommendations from our last inspection

1.13 The reception area was in need of basic improvements that would create a more welcoming environment and promote a positive experience for prisoners upon arrival. The regime on the first night centre was poor and cells that had been approved as suitable for occupation were dirty, lacked basic items and were not prepared for use.

1.14 The number of times that force had been used had reduced since our last inspection but remained higher than many similar prisons. We were assured that incidents were proportionate and there was evidence of de-escalation. The segregation unit was reasonably clean, but some cells were damp. The daily regime was poor, but there was now a better focus on the reintegration of segregated prisoners, including some with complex needs, back into the mainstream population.

1.15 Security arrangements were generally proportionate and aligned to risk, but a backlog of intelligence reports was waiting analysis. The supply of illicit drugs and other items remained a clear threat, so we were surprised to find that a body scanner in Reception was not used often enough and drug testing had yet to recommence.

Respect

At the last inspection of Chelmsford in 2018 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection we found that outcomes for prisoners remained not sufficiently good.

1.16 In our survey, two-thirds of prisoners said that most staff treated them with respect, but the most common reports we received were of staff being dismissive, failing to respond to requests and being unable to show care or compassion. This caused prisoners great frustration and prison leaders suggested this was linked to an increase in assaults on staff. This negative and damaging staff culture undermined many aspects of the prison's work, including its support of rehabilitation. Lack of management oversight of staff and limited accountability enabled poor behaviour to go unchallenged. Many staff, for example, had witnessed poor behaviour among their peers and too few took responsibility for the duties to which they had been deployed.

1.17 The older parts of the prison were cramped and overcrowded. The newer wings were better laid out, brighter and more open. Standards of cleanliness in communal areas had improved, but many cells were dirty and in poor repair. There was a shortage of basic kit, such as pillows, decent mattresses and kettles. Oversight of response times to cell bells was not good enough and some went unanswered for far too long.

1.18 The quality and quantity of food needed improvement. Most prisoners told us the prison shop sold what they needed, although new arrivals still had to wait up to 11 days to receive their first order.

1.19 The promotion of equality had improved since the last inspection. However, weaknesses remained, and provision had been further diminished by COVID-19 restrictions. There was now a monthly meeting to oversee equality work and a good partnership had developed with Ipswich and Suffolk Commission for Racial Equality. A wide range of equality data was collated, but its analysis was generally weak. The quality of most discrimination complaint investigations and responses was, however, good. There had been some reasonable efforts to provide translated material for non-English speaking prisoners, but professional telephone interpreting was not always used when required. Insufficient attention had been paid to meeting the needs of those with disabilities or younger prisoners.

1.20 Weaknesses in partnership working between the prison and health services persisted. While some aspects of health care had improved, significant staffing shortages in the pharmacy and mental health teams were having a negative impact. The management of long-term health conditions and complex needs had generally improved, and prisoners over 50 were screened to assess their ability to complete daily activities. Partnership working between the prison and Essex County Council in relation to social care needed improvement. Despite this, social care outcomes for prisoners were generally good. Substance misuse clinical and psychosocial services were very good. Patients requiring transfer to secure mental health facilities continued to wait too long for a place.

Purposeful activity

At the last inspection of Chelmsford in 2018 we found that outcomes for prisoners were poor against this healthy prison test.

At this inspection we found that outcomes for prisoners remained poor.

1.21 Ofsted carried out a progress monitoring visit of the prison alongside our full inspection and the purposeful activity judgement incorporates their assessment of progress. Ofsted's full findings and the recommendations arising from their visit are set out in Section 5.

1.22 There was no current published daily regime. Recovery from COVID-19 restrictions was far too slow, and at the time of this inspection about half of the population were unemployed and locked in their cell for almost 23 hours a day, with an inevitable toll on their well-being. There were few constructive activities and little creative use of peer workers to promote time out of cell for prisoners. The library had only reopened during our inspection and the gym had reopened in June 2021, both being later than in many other prisons.

1.23 Leaders and managers had worked closely with the education provider during the national restrictions to make sure that prisoners had access to in-cell education through a variety of learning packs, and had successfully put in place their plans to bring back the full curriculum in education, skills and work. The number of prisoners accessing the available activity places had not been maximised; attendance was often too low and prisoners' punctuality was not always good.

1.24 The information, advice and guidance prisoners received at their induction was generally effective. However, the ongoing advice and guidance was not planned and developed well enough to help prisoners move on to their chosen next steps.

Rehabilitation and release planning

At the last inspection of Chelmsford in 2018 we found that outcomes for prisoners were reasonably good against this healthy prison test.

At this inspection we found that outcomes for prisoners were now not sufficiently good.

1.25 In our survey, only 18% of prisoners said staff had encouraged them to keep in touch with their family and friends, but the prison had recently developed a positive strategy and action plan to improve this. Face-to-face social visits were not available at the weekend, and family days and parenting courses had stopped at the start of the pandemic. All the visitors we spoke to said they had been treated with respect during the visit, but that they had experienced significant delays in getting through to the booking office by telephone.

1.26 Management of reducing reoffending work had recently improved with a good analysis of offending-related needs, strategy and action plan. However, resettlement agencies were still not always seeing prisoners face to face. Even though offender management unit caseloads were relatively small, much of the time of uniformed prison offender managers (POMs) was lost through cross-deployment to other duties. POM contact with prisoners varied too much and the key worker scheme was not yet operating. Most eligible prisoners had an initial offender assessment system (OASys) assessment and resettlement plans were completed on time, although in our survey, only 14% of prisoners said they had a plan.

1.27 Public protection arrangements were inadequate. The inter-departmental risk management team had not been functioning since the start of the pandemic, although this was partly mitigated by reasonable risk management planning by individual POMs. There was a backlog of phone calls waiting to be monitored and we were concerned that requirement to monitor was being removed without enough supporting evidence to do so.

1.28 Initial categorisation and reviews were timely and most prisoners were moved promptly to another prison following sentencing. However, there

were some difficulties in transferring Category B prisoners and those convicted of sex offences.

1.29 The innovative range of interventions to address offending behaviour that we noted in our 2018 report had ended. The psychology department supported some prisoners individually, but POMs were not trained to deliver specialist interventions for those convicted of sexual offending or domestic violence.

1.30 The quality of pre-release resettlement plans was reasonably good, but in our survey, only 35% of prisoners due for release said someone was helping them to prepare for this. Too many prisoners were released without a suitable or sustainable address to go to and monitoring of this issue was poor. Support for prisoners' finance, benefit and debt problems was weak. The positive pre-release resettlement 'drop-in' facility had not yet fully reopened and there was little basic support on the day of release.

Key concerns and recommendations

1.31 Key concerns and recommendations identify the issues of most importance to improving outcomes for prisoners and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of prisoners.

1.32 During this inspection we identified some areas of key concern and have made a small number of recommendations for the prison to address those concerns.

1.33 Key concern: 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. Levels of violence remained among the highest of all local prisons since 2018. Analysis of data was poor, preventing a deeper understanding of risks, so it was unsurprising that plans to tackle violence and improve outcomes were limited or non-existent. The lack of accountability over staff manifested itself in an over-reliance on the small safer custody team, whose work was given insufficient priority, and in the failure of other staff and senior leaders to take responsibility.

Recommendation: Levels of violence should be reduced significantly so that prisoners feel safe. All staff should be clearly committed to reducing violence. Good data analysis should underpin this progress by providing a better understanding of the risks and required actions.
(To the governor)

1.34 Key concern: Evidence showed that the supply of drugs remained a key threat to safety and the health of prisoners at Chelmsford. Despite efforts to reduce this there were some gaps in the approach. For example, drug testing was not taking place and the body scanner was not used to full effect.

Recommendation: Drug supply should be reduced further through the delivery of an effective strategy and action plan which makes use of all the available methods including increasing the use of the body scanner and restarting drug testing for prisoners.
(To the governor)

1.35 Key concern: 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 and this is the fourth consecutive inspection where we have reported significant increases in the rate of self-harm. We found that the Listener scheme (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) had stalled and there were many weaknesses in the ACCT and other preventative processes. There were further failings in night safety procedures, delays in responding to cell bells and a lacklustre approach to data, learning and action planning.

Recommendation: Work to prevent suicide or self-harm should be improved significantly. The use of Listeners, ACCT case management and other preventative measures should be delivered proactively and robustly. Data analysis, learning and action planning should support the delivery of improved outcomes for prisoners.
(To the governor)

1.36 Key concern: Prisoners experienced real frustrations in getting anything done. 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 prisoners with disabilities and mental health problems. A dominant staff culture, which we describe as negative and damaging, led to the failure to support or promote safety, decency or rehabilitation among prisoners. Too many staff were dismissive in their dealings with prisoners or evidenced only limited empathy for those for whom they were responsible. A lack of accountability and management oversight of staff enabled poor practice to go unchallenged and in our staff survey, too few felt that managers set high standards of behaviour.

Recommendation: Prisoners' perceptions of their treatment should be improved. Staff must have higher expectations of prisoners and take personal responsibility for the promotion of safety, decency and rehabilitation. Staff should engage constructively with prisoners, respond positively to their reasonable requests and managers should hold them to account.
(To the governor)

1.37 Key concern: Many cells were cramped, in poor repair and grubby, and those on the first night unit remained poorly prepared. Many cells were graffitied and had inadequate furniture, and there was a shortage of pillows, decent mattresses and kettles. Many shared cells had no toilet screening and some toilet seats and lids were broken. The infestation of rats persisted on some wings and in serveries, and rubbish had been allowed to accumulate in some areas which only served to exacerbate this problem.

Recommendation: Prisoners should live in a clean and decent environment that is in a good state of repair and fit for purpose.
(To the governor)

1.38 Key concern: Significant staff shortages in health care, particularly in the mental health and pharmacy teams, had affected the delivery of services. Many prisoners had experienced delays in receiving their medication, which was detrimental to their care, and some aspects of medicines management was unsafe. There was an over-reliance on agency staff, particularly in the mental health team, which meant that service continuity could not be guaranteed. There were still weaknesses in partnership working between the prison and the health service, with inconsistent officer support to manage medicine administration effectively and enable clinics to run efficiently, and too frequent cancellations of external hospital appointments.

Recommendation: The health needs of prisoners should be fully met and the management of medicines should be safe. Prisoners should be able to attend all their clinical appointments.
(To the governor and the healthcare provider)

1.39 Key concern: Many prisoners were locked in their cell for almost 23 hours a day, with an inevitable toll on their well-being. This reflected in part the COVID-19 restrictions but even in 2018 when we last inspected, we found many prisoners locked in cell for 22 hours day. Plans to introduce a meaningful regime were limited and being implemented far too slowly.

Recommendation: Prisoners should have regular and predictable time out of cell, which is sufficient to promote rehabilitation and mental well-being.
(To the governor)

1.40 Key concern: Public protection arrangements were not robust. The inter-departmental risk management team had not met since early 2020, leaving no clear oversight and audit of risk management arrangements for the release of prisoners posing the highest risk, including those managed under multi-agency public protection arrangements (MAPPA). There was a backlog of phone calls waiting to be monitored for public protection concerns, which presented further gaps in risk management.

Recommendation: Public protection measures and oversight to manage those presenting a risk of serious harm should be applied robustly.
(To the governor)

Notable positive practice

1.41 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

1.42 Inspectors found two examples of notable positive practice during this inspection.

1.43 Prisoners could access support from the chaplaincy through a free phone line. It was used by prisoners struggling to get their daily needs met, and the support provided by the team potentially prevented issues from escalating. (See paragraph 4.35.)

1.44 Health staff screened all prisoners over 50 to assess their ability to complete daily living activities, identifying needs and offering further support when needed. (See paragraph 4.56.)

Section 2 Leadership

Leaders provide the direction, encouragement and resources to enable good outcomes for prisoners. (For definition of leaders, see Glossary of terms.)

2.1 Good leadership helps to drive improvement and should result in better outcomes for prisoners. This narrative is based on our assessment of the quality of leadership with evidence drawn from sources including the self-assessment report, discussions with stakeholders, and observations made during the inspection. It does not result in a score.

2.2 At our last inspection in 2018, we decided not to initiate an Urgent Notification (see Glossary of terms), largely because HMPPS had placed Chelmsford in a programme of special measures and we were led to believe that this would bring significant improvements and, in the process, address our key concerns and recommendation. At this inspection, we followed up progress against our key concerns and recommendations and found that none had been fully achieved. In autumn 2020, HMPPS recognised the need to provide further support to improve outcomes by introducing another performance improvement plan but progress with this had been delayed for far too long and support was unlikely to be fully actioned until at least October 2021.

2.3 There had been significant changes in the leadership team at the prison over recent months, including the arrival of a new governor and deputy. They had clear ambitions to drive forward performance and were committed to improvement, but the wider staff group still needed to be engaged more fully in understanding and taking forward the new priorities. Of the 81 staff who completed our survey, only 33% thought priorities had been clearly communicated and just 7% said they had been very clearly communicated; over a third of staff disagreed with the priorities.

2.4 The commitment to improving safety was not matched by the staff resources allocated to the safer custody team, a problem compounded by persistently high cross-deployment of team members to other duties. Partnership working was not always as strong as it should have been. For example, the relationship between the health care providers and the prison needed improvement to make sure services were delivered as intended.

2.5 The collection and use of data were weak in many key functions and action to make improvements was lacking, even when data indicated it was needed. Analysis was not used well to spot themes and trends or to make strategies specific to Chelmsford. Consequently, too many strategies were of a poor quality and few action plans gave us confidence that the proposed next steps would be effective. Leaders had neglected Prisons and Probation Ombudsman and HMI Prisons action plans; this was poor given the areas of repeated concern including, for example, the number of self-inflicted deaths over the last

three years. Consultation with prisoners was also very limited and prisoners had not been able to participate in the prison council for over a year (see paragraph 4.16).

2.6 A few staff we spoke to were positive and committed to providing good care to prisoners, understanding more fully the importance of rehabilitation. However, a lack of accountability and management oversight of staff had enabled poor practice to go unchallenged. In our staff survey, too few felt that managers set high standards of behaviour or challenged poor behaviour by others – 44% of those who responded said they had witnessed inappropriate staff behaviour to prisoners and half said they had witnessed inappropriate behaviour between staff. (See key concern and recommendation 1.36.) Staff coaching and training had been neglected during the COVID-19 restrictions, even though almost a third of officers had less than two years in post. There was no current training plan, although a newly appointed manager was seeking to rectify this. In our staff survey, 32% thought that the support for their well-being was quite poor and a further 23% thought it was very poor. In addition, 41% said their morale was low and 28% said it was very low.

2.7 A large-scale outbreak of COVID-19 in the first few months of 2021 had made it difficult for the prison to deliver even the very basic regime for several weeks. The outbreak was managed well overall, but since then the pace of recovery from the restrictions had been far too slow. For example, the library had only just reopened during our inspection and there were too few social visits, with none at weekends. Most prisoners spent almost 23 hours a day locked in their cell. The number of unemployed prisoners was high and, even when allocated to education, attendance and punctuality were poor.

Section 3 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

Expected outcomes: Prisoners transferring to and from the prison are safe and treated decently. On arrival prisoners are safe and treated with respect. Risks are identified and addressed at reception. Prisoners are supported on their first night. Induction is comprehensive.

3.1 Chelmsford remained a busy local prison, receiving around 48 new arrivals a week. Prisoners were routinely handcuffed when leaving the escorting vehicle, which was unnecessary. All prisoners were strip searched in reception, which was excessive, as a body scanner was available and should have been used instead. (See key concern and recommendation 1.34.)

3.2 The reception area needed further improvement. For example, holding rooms were bare and some toilet areas lacked screening from the main corridor.

3.3 Reception processes were efficient. Prisoners received a private safety interview and were seen by a nurse (see paragraph 4.57) before they were taken to the induction unit on B wing, where they received an additional private first night interview. Although this was good practice, this interview was often delayed due to the high number of new arrivals. All prisoners in custody for the first time or whose circumstances had changed received additional safety checks during the night.

3.4 As at the previous inspection, cells on the first night unit remained poorly prepared. Those we inspected were dirty and contained graffiti. Not all in-cell phones were working and there was a shortage of some basic items such as pillows (see paragraph 4.6 and key concern and recommendation 1.37.)

3.5 The regime on the first night centre was poor with prisoners locked up for 23 hours a day, with only 30 minutes for exercise and 30 minutes to complete domestic tasks. Although arrivals were only expected to stay on the unit for 14 days, some had been there for longer due to a lack of spaces on other units.

3.6 The full face-to-face induction programme had been suspended at the start of the pandemic and had not yet restarted. In our survey, only 27% of the prisoners who said that they received an induction said that it covered everything they needed to know about the prison, which was significantly lower than at the last inspection.

Managing behaviour

Expected outcomes: Prisoners live in a safe, well ordered and motivational environment where their positive behaviour is promoted and rewarded. Unacceptable conduct is dealt with in an objective, fair, proportionate and consistent manner.

Encouraging positive behaviour

3.7 Chelmsford remained an unsafe prison. The number of violent incidents was still among the highest of all local prisons and had begun to increase again over the last six months. Prisoners' perceptions of safety had not improved since our 2018 inspection. In our survey at this inspection, nearly half of all respondents said that they had experienced some form of victimisation by staff, and those with disabilities or mental health issues were even more negative in their perceptions of safety. There had been no recent consultation with prisoners to identify or discuss their concerns (see paragraph 4.16), and the use of conflict resolution peer support workers had ceased.

3.8 Although prison leaders had highlighted safety as a key priority, there was too much reliance on the very small safer custody team to address the issue. The team was not resourced or deployed consistently, and they were given insufficient support from other key functions and departments within the prison.

3.9 The new governor had recently begun to attend the strategic safety meetings, emphasising the importance of this priority, but attendance by others was limited. Data was not analysed well enough to identify key risks or review progress. A weekly safety interventions meeting was better attended and provided improved oversight of some individual prisoners, including those with complex needs.

3.10 A new violence reduction policy had been published recently. While it contained some useful guidance for staff, it was mainly a description of HMPPS processes and not specific to the challenges facing Chelmsford. There was no accompanying action plan to drive progress in tackling violence and other aspects of safety. (See key concern and recommendation 1.33.)

3.11 There was little done to manage prisoners engaged in violent acts and, as we identified in 2018, too much reliance on the use of disciplinary procedures or the limited local incentives policy (see paragraph 3.14). Despite the large number of assaults, only 14 prisoners were on formal monitoring under the challenge, support and intervention plan (CSIP, see Glossary) process.

3.12 Members of the safer custody team undertook the initial screening when actioning a CSIP. However, too many referrals did not result in a behaviour improvement plan being opened which meant that poor and violent behaviour by perpetrators remained unchallenged. There was

similarly no structured quality assurance or monitoring of the use of CSIP to evidence it effectiveness.

3.13 Support for victims of violence was equally poor, usually limited to just a change of location, with nothing done to identify or address the underlying issues. We also identified several prisoners hiding in their cells due to fears for their own safety. Support for them was haphazard and there was no wider consideration of a formal management plan or strategy to support them.

3.14 There were too few incentives to promote good behaviour and develop a rehabilitative culture in the prison. Some prisoners on the enhanced level of the incentives policy benefited from single cell accommodation on G wing, but many told us that there was little else to encourage positive behaviour. Prisoners on basic were reviewed regularly, but little was done to help them change their behaviour.

Adjudications

3.15 Over the last year, too many adjudications, around a quarter, were dismissed or not proceeded with, some of which were for serious breaches of rules, such as possession of illicit items or acts of violence. In the cases we reviewed, this was often due to the time taken to bring the charge to conclusion or basic administrative errors, which undermined the effectiveness of the process. However, the prison had worked hard to address the number of adjourned charges and there were very few outstanding at the time of this inspection.

3.16 Adjudication data were presented to the segregation monitoring and review group (SMARG, see paragraph 3.27). Records of hearings were not always legible and lacked evidence of sufficient enquiry which made it difficult to see how conclusions were reached. The prison was unable to provide evidence of a quality assurance process and we identified several charges, for example, that could have been dealt with by other means.

Use of force

3.17 There had been 774 uses of force in the last year, which was a slight reduction when compared with our previous inspection. However, data evidenced that spontaneous use of force, which often involved younger prisoners, was higher than at most other local prisons.

3.18 Routine oversight of the use of force had been poor but shortly before our visit, senior leaders had begun to introduce more frequent reviews which was positive. There was no dedicated use of force coordinator, although the SMARG (see paragraph 3.16) was used to provide some oversight. Where concerns were identified, managers did respond and took robust action, but more systematic quality assurance arrangements were not well embedded.

3.19 We were satisfied that the use of force incidents we reviewed were proportionate and we found evidence of de-escalation. Documentation

was mostly complete. However, even though body-worn video cameras were readily available, too many staff failed to activate them during an incident to provide evidence and support de-escalation. Where footage was available it was not always retained for review. The prison also failed to routinely deploy hand-held video recorders in planned use of force incidents.

3.20 There had been 26 recorded uses of special accommodation in the previous 12 months with an average stay of over five hours. Completed records were of a poor quality. For example, management checks were not recorded and there was poor recording of regular observations by staff. In addition to special accommodation, the prison also used what were referred to as 'calm down' rooms in the segregation unit. We were offered differing accounts to their intended purpose and there was evidence that they were sometimes used as special accommodation without the relevant authority or oversight in place.

Segregation

3.21 The use of segregation had increased since the last inspection with 603 uses in the preceding 12 months. The increase was mostly due to an increase in prisoners being held for short periods prior to an adjudication hearing. Lengths of stay on the unit were relatively short for most, and most usually returned to normal location. Stays were properly authorised, although prisoners were still strip searched on arrival without an individual risk assessment to justify this.

3.22 The daily regime on the unit was poor with just a telephone call, shower and outside exercise. Some prisoners in the unit had been able to access PE sessions, although COVID-19 restrictions meant these occurrences had been less frequent recently. There was evidence of good work to reintegrate prisoners, many of whom had complex needs, back to normal location in the prison.

3.23 Communal areas in the segregation unit were now reasonably clean. The refurbished showers provided more privacy. Cells were freshly painted, but some toilets remained stained and drainage problems made some cells damp. The exercise yard remained austere and, at times, littered.

Security

Expected outcomes: Security and good order are maintained through an attention to physical and procedural matters, including effective security intelligence and positive staff-prisoner relationships. Prisoners are safe from exposure to substance use and effective drug supply reduction measures are in place.

3.24 In the previous 12 months, target searches had led to 282 drug finds which evidenced that this remained a clear threat to safety within the prison. Some positive steps had been taken to reduce the supply of drugs, such as photocopying mail arriving at the prison, some of which

was suspected of being contaminated. However, we were surprised that the body scanner located in reception was not used on all new arrivals to detect items secreted internally and drug testing had remained suspended due to COVID-19. (See key concern and recommendation 1.34.)

3.25 Physical security arrangements were generally proportionate and aligned to risks. However, the routine strip searching of all prisoners in reception despite the availability of a body scanner was not necessary (see paragraph 3.1). Restraints were also used on prisoners being escorted to hospital without a detailed and individualised risk assessment to justify this.

3.26 The prison had a good awareness of the key threats. The monthly local tactical assessment was thorough and provided an overview of key security concerns. However, the minutes of monthly security meetings were brief and lacked analysis of data or identification of actions to make sure that progress was made. There had been 10,565 intelligence reports submitted in the previous 12 months, but they were not always analysed quickly, leading to a large backlog.

3.27 Links with the police were good and police intelligence officers worked well with the security team. There was interagency work to manage gangs and identified extremists. Work to tackle staff corruption was very good. Prison managers worked effectively with the police when staff corruption was suspected, and this had yielded some positive results.

Safeguarding

Expected outcomes: The prison provides a safe environment which reduces the risk of self-harm and suicide. Prisoners at risk of self-harm or suicide are identified and given appropriate care and support. All vulnerable adults are identified, protected from harm and neglect and receive effective care and support.

Suicide and self-harm prevention

3.28 Since our last inspection there had been eight self-inflicted deaths, of which four occurred during the preceding 12 months. There had also been four non-natural deaths. In the previous 12 months, there had been 848 incidents of self-harm by 235 prisoners, a large increase since 2018 and consistent with a continuous increase across our four most recent inspections of the prison. Chelmsford now had the second highest rate of self-harm out of all local prisons.

3.29 There was no current strategy to reduce self-harm and no detailed analysis of data that enabled a better understanding of the causes and drivers for self-harming behaviours. (See key concern and recommendation 1.35.)

3.30 Despite some serious failings identified by investigations undertaken by the Prisons and Probation Ombudsman (PPO) as well as others following deaths in custody, our previous key concern and recommendation about self-harm had not been achieved. The prison's action plan to address PPO recommendations was out of date and many PPO recommendations were repeated over successive action plans. Leaders had, for example, repeatedly failed to address problems, such as the deficiencies identified in assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm. (See key concern and recommendation 1.35.)

3.31 There had been over 1,000 ACCTs opened in the last 12 months which was an increase on previous years. Some prisoners we spoke to said they had received very limited support whilst on the ACCT. Staff lacked confidence in using the new ACCT document and we found many weaknesses in its completion. Care plans were missing or incomplete, and risks, triggers and sources of support were rarely identified. Records of interaction with prisoners were often missing, case management was inconsistent, and supervisors did not always complete daily checks on the documentation.

3.32 Staff we spoke to on a night shift generally knew who was on an ACCT but had no detailed knowledge of the risks presented. We observed other serious flaws in practice at night. For example, not all staff carried an anti-ligature tool; most we spoke to said they would always wait before entering a cell in an emergency, which would cause a delay in the prisoner receiving the emergency help they needed; and some were unaware of the location of the defibrillators or how to use them.

3.33 At the time of our inspection, there were only nine Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners), which was too few. In our survey, only 34% of respondents said that it was easy to speak to a Listener if they wanted to, compared with 54% at our last inspection. The Listeners were enthusiastic and positive about their role and the support they received from the Samaritans. However, they also reported concerns about staff not facilitating requests to see them, including prisoners being told that a Listener was not available when they were.

3.34 Access to Listeners was also hindered by prisoners' lack of time of out cell and the limitations on prisoners mixing across groups during the COVID-19 restrictions, which made it difficult for Listeners to move between units. There were no formal arrangements for Listeners to meet regularly with the safer custody department, which may have helped resolve some of these concerns.

Protection of adults at risk (see Glossary of terms)

3.35 The prison's safeguarding adults policy was brief, focused mostly on the identification of safeguarding concerns for new arrivals and did not explain what made a prisoner vulnerable or provide guidance on how to protect them. Most staff we spoke to were unfamiliar with adult

safeguarding and associated procedures, which increased the risk that needs were missed.

3.36 Links with the local safeguarding adults board had lapsed and nobody from the prison had been attending board meetings.

Section 4 Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

Expected outcomes: Prisoners are treated with respect by staff throughout their time in custody and are encouraged to take responsibility for their own actions and decisions.

4.1 A dominant negative and damaging staff culture persisted and led to the failure to support or promote safety, decency or rehabilitation among prisoners. This culture had been allowed to go unchallenged for far too long. In our survey, significantly fewer prisoners than in 2018 said 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 prisoners with disabilities and mental health problem. Many said that staff failed to respond to even basic requests from them and were dismissive in their dealings or evidenced only limited empathy for those for whom they were responsible. Prisoners experienced real frustrations 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, one prisoner commented: *'To get anything you need from staff is like getting blood from a stone, you just won't get it'.* (See key concern and recommendation 1.36.)

4.2 HMPPS had recently held a series of staff forums in response to concerns about staff culture, but this review was not yet complete. As at our last inspection, there were plans to provide additional support for staff, but training had been neglected for too long. In particular, the lack of staff training in mental health awareness and managing trauma were significant gaps in promoting a rehabilitative culture across the prison.

4.3 Key working was being relaunched at the time of the inspection. However, plans to restore it were unambitious and did not mirror what was intended by the Offender Management in Custody (OMiC) model (see Glossary of terms). The plans would not necessarily promote consistent one-to-one support for prisoners, and links between key workers and prison offender managers (POMs) were not clear.

Daily life

Expected outcomes: Prisoners live in a clean and decent environment and are aware of the rules and routines of the prison. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair.

Living conditions

4.4 In our survey, just 17% of prisoners said their cell bell was normally answered within five minutes and in the records we looked at, there were delays of up to 39 minutes. This was a particular concern given the high and increasing rate of self-harm.

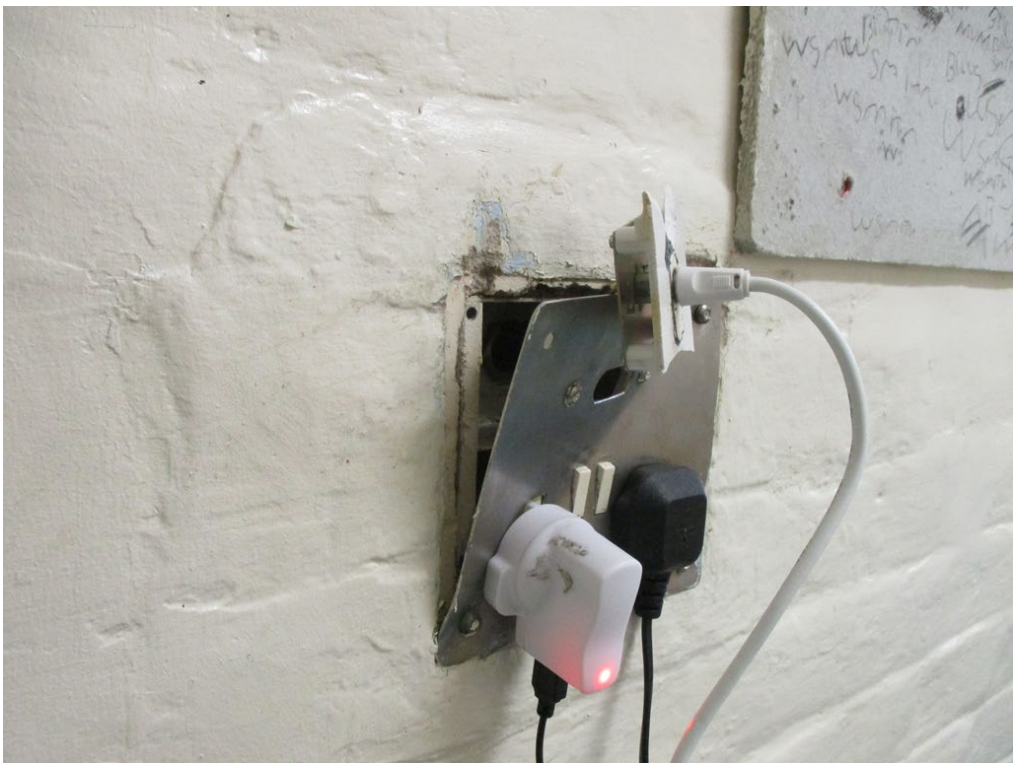
4.5 Conditions on the four older wings (A, B, C and D) were cramped with 70% of prisoners living on those wings sharing a cell designed for one person. The other three wings had been built more recently and were better laid out and brighter but some of those prisoners also shared a cell designed for one.

B wing upper landing

E wing landing

4.6 Standards of cleanliness in most communal areas had improved since our last inspection but some showers remained poor. Many cells were in poor repair and very grubby. Many shared cells had no toilet screening and some toilet seats and lids were broken. Cells were often graffitied and possessed inadequate furniture. There was a shortage of some key amenities, including pillows, decent mattresses and kettles. At the start of the inspection, for example, about half the prisoners in the induction wing did not have a pillow. (See key concern and recommendation 1.37.)

Condition of C wing showers



Loose electrical fitting

4.7 Despite work to control the issue, there was still a significant problem with rats, including on wings and in food servery areas. Although efforts were made to clean outside areas, rubbish had accumulated on flat-roofed areas outside wings and in some cell window grilles.

Rubbish in window grills

4.8 In our survey, only 55% of prisoners said they normally had enough clean, suitable clothes for the week and only 50% said they had clean sheets every week. Wing laundry facilities were inadequate, with up to 120 prisoners sharing two domestic washing machines, which we were told often broke down. Weekly kit changes sometimes did not happen. Prisoners complained that the central laundry did not always return items such as sheets and pillowcases, which they had to go without until the next kit change.

4.9 In our survey, only 13% of prisoners said they could get their stored property promptly if needed. Access to property made up the highest percentage of complaints to both the prison and the Independent Monitoring Board.

Recommendation

4.10 **Calls using cell bells should be responded to promptly.**

Residential services

4.11 In our survey, only 19% of prisoners said the food was good. Hot meals were left sitting in the servery for too long and the food we tasted was bland and unappetising. Only 16% said they had enough to eat at mealtimes. Supervision of the serving of food was lacking and we observed serveries running out of food causing avoidable delays whilst more was obtained. We were told this was a frequent occurrence. On two wings, we saw lunch being served at the cell door, which was disrespectful.

4.12 The main kitchen was unkempt and grubby. Several items of equipment were in poor repair and had been out of order for a long time. Poor drainage meant that water pooled in cooking areas.

A dirty fryer in the kitchen

4.13 Most prisoners told us the prison shop sold what they needed, although new arrivals still had to wait up to 11 days for a first full order to be delivered. Interim packs could be obtained if requested.

4.14 Prisoners had raised the lack of cultural diversity in meals and prison shop goods in several consultation meetings. The prison needed to do more to understand and act on their views.

Recommendation

4.15 **Prisoners should be served food of good quality and sufficient quantity.**

Prisoner consultation, applications and redress

4.16 The prison council had lapsed during COVID-19, although managers had met remotely to discuss issues, no prisoners had been invited to attend.

4.17 Application forms were widely available on wings, but confidence in the process was low. In our survey, only 31% of prisoners said that applications were dealt with fairly. There was no quality assurance and many prisoners were frustrated that their requests were not addressed on time or in full.

4.18 Data analysis showed that responses were late in over 32% of cases, which was higher than at our last inspection and needed to improve. We saw some good responses to general complaints raised formally by prisoners, but others we sampled were curt and did not always address the issues raised. There had been 224 formal complaints submitted directly to the governor under the confidential access procedure. Most of these were about staff attitudes and reflected prisoners' frustrations about being unable to get things done or get their legitimate concerns addressed.

4.19 There was no formal legal support for prisoners, although the offender management unit (OMU) could provide information about local solicitors. A range of legal material was available in the library and access to legal visits was adequate, but there were some delays in solicitors being able to book these.

Recommendation

4.20 **The prison should maintain effective and timely applications and complaints systems that are subject to robust quality assurance.**

Equality, diversity and faith

Expected outcomes: There is a clear approach to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relationships. The distinct needs of prisoners with particular protected characteristics (see Glossary of terms) and any other minority characteristics are recognised and addressed. Prisoners are able to practise their religion. The chaplaincy plays a full part in prison life and contributes to prisoners' overall care, support and rehabilitation.

4.21 Insufficient staff had been allocated to equality work and the equality adviser was routinely redeployed to other duties, spending as little as two days a week in the role. Lead managers had been assigned for most of the protected characteristics, but in practice some leaders were doing little to promote better outcomes in their area. Each diversity peer representative had regular contact with the equality advisor to gain help and support, but COVID-19 had prevented them from meeting as a group.

4.22 There was no effective strategy to improve provision, and action planning was limited. However, there was now a monthly meeting to oversee equality work, supported by strong partnership working with Ipswich and Suffolk Council for Racial Equality (CRE). The meeting was informed by some particularly good consultation with black and minority ethnic prisoners, led by the CRE, but it was much less focused on the needs of prisoners in other protected groups, with whom consultation had been very limited.

4.23 A wide range of equality data were collated, but analysis was weak. There was insufficient discussion and action on some areas of

disproportionate treatment, such as the use of force against black and minority ethnic and younger prisoners.

4.24 The discrimination complaints process was better promoted than at our last inspection. There had been 75 complaints submitted in the previous 12 months, significantly more than in 2018. Most responses were reasonably prompt and the quality of investigations was good. The governor quality assured all responses and the CRE provided some independent quality assurance.

Recommendation

4.25 **Outcomes for prisoners in protected groups should be improved through the implementation of a comprehensive strategy that is informed by consultation and effective analysis of data.**

Protected characteristics

4.26 Over one quarter of the population were from a black or minority ethnic background. In our survey, black and minority ethnic prisoners reported less favourably than white prisoners on their relationships with staff; only 43%, compared with 71%, said that most staff treated them with respect. The prison was working very well with the CRE to promote outcomes for black and minority ethnic and foreign national prisoners.

4.27 Foreign nationals made up 14% of the prison population. There had been some reasonable efforts to provide translated material, but professional telephone interpreting was not always used when required.

4.28 Although the Home Office had recommenced twice-weekly onsite visits to the prison in April 2021, foreign national prisoners had poor access to free independent legal representation and little awareness of support organisations. The library contained one out-of-date textbook on immigration law.

4.29 There was little evidence of any effective management oversight of treatment and conditions for prisoners with disabilities. In our survey, 39% of prisoners considered themselves to have a disability; they reported feeling less safe than prisoners without disabilities and only 12% said they were getting the support they needed. Wing staff had limited awareness of prisoners with hidden disabilities, such as autism or attention deficit hyperactivity disorder (ADHD). Some prisoners with physical disabilities were held in cells entirely unsuited to their needs. Some adapted cells and showers were in poor repair and grubby.

Shower with disability adaptations

4.30 Arrangements for the evacuation of prisoners with disabilities in an emergency were inadequate. Those who needed assistance were not clearly identified to staff, who were unable to locate evacuation plans. Informal arrangements for prisoners to provide support to those with disabilities were not supervised, leaving the latter at risk of exploitation.

4.31 Despite the easing of restrictions, we still found older prisoners and those with disabilities locked in their cells for most of the day. Despite evidence of need there was little specific support for older prisoners. A youth council for young adults had continued to meet throughout much of 2020, but it was currently suspended. The younger persons' strategy was predicated on the provision of a good regime and had not been adjusted to account for COVID-19 restrictions. There was insufficient action on data showing disproportionate adverse treatment of prisoners in this group.

4.32 There had been little dedicated support for gay and bisexual prisoners during the pandemic. However, we found some good support for transgender prisoners.

Recommendation

4.33 **Professional telephone interpretation should always be used when necessary.**

Faith and religion

4.34 In our survey, only 60% of prisoners said their religious beliefs were respected, compared with 79% at our last inspection. Only 46% of Muslim prisoners said their beliefs were respected. This might have reflected the suspension of corporate worship during the COVID-19 pandemic and delays in reinstating this.

4.35 The chaplaincy had worked hard to mitigate the suspension of services by visiting prisoners frequently to attend to their spiritual and pastoral needs. This support was supplemented by a free telephone line to the chaplaincy, which was often used by prisoners struggling to get their daily needs met; the support provided by the team potentially prevented issues from escalating.

4.36 Throughout the pandemic, the team had continued to undertake its mandatory duties, such as seeing all new arrivals and those on an ACCT (case management for those at risk of suicide or self-harm) or in segregation. There was support for prisoners who had been bereaved and there had been good use of iPads, for example, for prisoners to attend funeral services screened online. The team continued to provide good one-to-one support for prisoners in the Travelling community.

Health, well-being and social care

Expected outcomes: Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.

4.37 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC issued 'requirement to improve' notices following the inspection (see Appendix III).

Strategy, clinical governance and partnerships

4.38 NHS England and NHS Improvement had commissioned Castle Rock Group Medical Services Limited (HRCG) to provide health services since April 2019. The provider had inherited a challenging service and had made some positive changes since then, but some aspects remained poor. Significant staff shortages, particularly in the mental health and pharmacy teams, had affected the effective delivery of these services. Many prisoners told us that they had experienced delays in receiving their medication and we found multiple examples of this that interrupted ongoing treatment and the start of new treatment, which

was detrimental to patient care. (See key concern and recommendation 1.38.)

4.39 NHS England and NHS Improvement had undertaken quality visits to support the provider in addressing areas of concern. Regular contract review meetings and virtual partnership board meetings had continued. However, there remained some weaknesses in partnership working between the prison and health care service with longstanding problems, such as inconsistent officer support to manage medicine administration effectively. (See key concern and recommendation 1.38.)

4.40 A significant outbreak of COVID-19 between January and April 2021 had been effectively managed involving key stakeholders. The roll-out of the national COVID-19 vaccination programme had been progressing well until recently, when 70 prisoners had received expired vaccinations. The incident had been dealt with appropriately and all prisoners involved had been offered another vaccination.

4.41 All the staff we spoke to felt supported by the health care manager and the clinical lead, both of whom had implemented positive changes. Regular clinical and managerial supervision was being embedded and there was a focus on improving compliance with mandatory training, which was now at acceptable levels.

4.42 Monthly clinical governance meetings had been established and the management of clinical incidents had improved since the last inspection. There was analysis of trends and any lessons learned were shared with staff. There was also good oversight of the health recommendations from Prisons and Probation Ombudsman death-in-custody reports, and regular audits and patient feedback informed service delivery.

4.43 There was a confidential health complaints process. Complainants received prompt typed acknowledgments, but subsequent responses were handwritten. Most responses were respectful and addressed the issues raised, but a few lacked focus and further quality assurance was needed. The responses did not inform patients how to escalate their complaint if they were unhappy with the outcome.

4.44 Prisoners had been able to use a phone line during the pandemic to identify a health concern or make an appointment. Many told us that it took a long time to get through, causing much frustration, and its use was under review. A paper application system had been running concurrently. Applications were collected daily from the wings and triaged appropriately.

4.45 The clinical records we examined were mostly satisfactory and record-keeping audits were completed. Prisoners' consent to share information was sought on their arrival and was well documented.

4.46 All health staff were trained in intermediate life support and had good access to well-maintained and regularly checked equipment. Health

staff reported that officers did not always call emergency codes appropriately and they were sometimes used for minor issues rather than those which required an urgent response.

4.47 Clinical rooms across the site were generally clean and well maintained. Regular Infection control audits showed good compliance, although a few issues needed to be addressed, including some damp in a consulting room and corridor, which had caused the paint to bubble. This had been escalated to the prison and was awaiting attention.

Recommendations

4.48 **Responses to health complaints should address the issues highlighted and inform prisoners about how to escalate their complaint if they are unhappy with the response.**

4.49 **There should be refresher training for officers on the use of codes for medical emergencies.**

Promoting health and well-being

4.50 A draft health promotion strategy was awaiting ratification and a health promotion impact group was being developed with staff from different areas of the prison enlisted to participate.

4.51 The main health promotion focus had been on managing COVID-19 and promoting the national vaccination programme. Uptake had been lower than expected, despite ongoing encouragement and education, and the recent error in vaccination (see paragraph 4.40) was a setback. Displays of health promotion posters and literature had been kept to a minimum in line with infection prevention and control guidance. Some laminated posters were displayed in the health centre, as well as COVID-19 information.

4.52 Health staff screened all prisoners over 50 to assess their ability to complete daily living activities. This had helped to identify prisoners who needed additional support, such as for memory deficits or continence issues, which was offered when needed, and was positive practice.

4.53 Smoking cessation services were running with individual sessions offered.

4.54 Some screening programmes had been affected by the pandemic; retinal screening had just restarted, and the abdominal aortic aneurysm screening service had been contacted to re-establish this provision.

4.55 Prisoners had good access to immunisations and screening for sexual health and blood-borne viruses and were supported by visiting specialists. Barrier protection was available, but not well advertised.

Primary care and inpatient services

4.56 A health care professional screened all new arrivals and made appropriate referrals. Identified risks were shared with relevant prison staff and the wider health team as necessary. Managers monitored referral processes in response to a recent death in custody, ensuring that all health staff had referral training. New arrivals received a secondary health screening within seven days, including COVID-19 testing.

4.57 Waiting times to see the GP was around two weeks, although patients with urgent needs could be seen within two days. The nursing team effectively triaged referrals, seeing patients in the health centre or on the wings. There was 24-hour nursing cover.

4.58 An appropriate range of health services was available, including physiotherapy and podiatry. Clinics had just recommenced and waiting times were long, but in line with those in the community. Only one officer was allocated to health care to manage prisoner movements to and from the centre. This caused delays in clinics starting and they were occasionally cancelled if no officer was allocated. As a consequence, patients missed their appointments and valuable clinical time was wasted. (See key concern and recommendation 1.38.)

4.59 Patients with long-term conditions received annual reviews. They all had a care plan that showed individual objectives, but staff recording of discussions with patients on the management of their complex long-term conditions was underdeveloped.

4.60 Two nurses were assigned to respond to emergencies during the day. However, they were responding to all general alarms, which affected their daily duties.

4.61 The prison provided only two hospital escorts a day and often cancelled appointments due to the lack of escort staff. (See key concern and recommendation 1.38.)

4.62 No patients were receiving palliative care at the time of inspection. There was a pathway for supporting patients on end-of-life care.

4.63 Prisoners due for release were given a full discharge summary that included a range of health care information, future appointments and a supply of medications if required.

4.64 The enhanced care unit, comprising 12 beds, was prison run, with health staff attending to prisoner needs when required. The GP and psychiatrist visited weekly and mental health nurses administered medication. Officers on the unit knew the prisoners well and were caring. Most prisoners there had mental health needs, but the unit lacked an overall therapeutic approach and its function was unclear. The prison could not provide a documented model of use. Most staff still referred to it as an inpatient unit.

Social care

4.65 There was a memorandum of understanding for the provision of social care between the prison and Essex County Council, although the prison could not produce its copy. Leadership of social care had been haphazard since April 2021, when the contract for the previous social care provider had lapsed and monthly oversight meetings between the prison and council had ceased.

4.66 The prison made at least one referral a month to the county council for social care assessment. The response was prompt and commonly within 24 hours, with assessments undertaken by a social worker and occupational therapist, as necessary. Packages of care for those meeting the threshold could commence within three days and at least one package was in place at the prison at any time. Advice was given to the prison on providing support for prisoners who did not meet the threshold, including the use of mobility and other aids from council equipment stored at the prison.

4.67 One prisoner we spoke to was receiving good care and his carer was content with the assistance she was receiving from the prison to complete her tasks. However, he had previously received no social care for three days following discharge from hospital, which was unacceptable. An informal package of care for him had to be urgently assembled until the council's package of social care commenced. The prison governor had investigated this matter to make sure it did not recur and had begun actions to improve the leadership of social care.

Mental health care

4.68 HRCG delivered primary and secondary mental health services. Forward Trust provided improving access to psychological therapies (IAPT) services, delivering counselling and psychological therapies. It was also commissioned to support a specific cohort of prisoners with suicide-risk factors, including prisoners aged 30 and under, those in prison for the first time and those charged with offences against family members. The aim was to provide support to reduce the risk of suicide; this was a promising initiative.

4.69 There had been significant staff turnover since the last inspection and the team had only recently stabilised with consistent agency staff, but service continuity could not be guaranteed. A team of 10 agency mental health nurses and two substantive health care assistants were overseen by an agency team leader. (See key concern and recommendation 1.38.)

4.70 Referrals for mental health services came from reception, officers and self-referral and were reviewed by a daily meeting. Appointments were offered within 24 hours if urgent or five days if not.

4.71 The nursing team delivered one-to-one interventions to 96 patients. There were currently 125 patients prescribed antipsychotic medication. The care programme approach was used effectively to support 10

patients with severe and enduring mental illness. The care plans we reviewed were of a high quality, evidencing patient involvement and personalised treatment. A visiting psychiatrist attended two days a week; despite a recent increase, this did not meet current demand.

4.72 The team were on site all week, but with reduced cover at weekends. The psychiatrist and nurses had continued to see patients face to face during the pandemic. Staffing challenges meant that patients did not have a named nurse or were not seen by the same nurse consistently, which was not conducive to developing therapeutic relationships or promoting continuity of care. (See key concern and recommendation 1.38.)

4.73 The mental health team attended all initial ACCT reviews and reviews for patients on the team caseload. The delivery of mental health services was based around ACCT reviews with high numbers of open ACCTs across the prison. This affected the day-to-day running of the service.

4.74 We were informed that several patients had waited lengthy periods to be transferred to mental health facilities, but detailed data were not available.

Recommendation

4.75 **Accurate data on transfers to mental health facilities should be used to analyse trends and demonstrate actions taken to make sure that patients do not wait too long for a transfer.**

Substance misuse treatment

4.76 Since April 2021, HRCG had contracted Forward Trust to provide integrated substance misuse services, with the Trust contributing to HRCG governance and oversight arrangements. The transition from the old provider had been smooth, and the Trust's services were well led and very good.

4.77 One side of E wing was designated as the drug interventions unit (with a reduced capacity since 2018) and prisoners also received care on other wings. The Trust contributed constructively to the prison's substance misuse strategy, ACCT and safety meetings.

4.78 Trust staff were fully occupied with 297 prisoners (41% of the population) in receipt of care from the psychosocial team. Although this was much higher than the 29% in 2018, challenges in filling staff vacancies persisted. The team had adapted working methods during the COVID-19 restrictions by making use of in-cell telephones to provide welfare checks and support patients. There were plans to reintroduce therapeutic groups from September 2021.

4.79 Clinical management of substance misuse followed national guidance. Patients were suitably reviewed by clinicians and psychosocial workers. Sixty-eight patients were on opiate substitution therapy (OST);

this was administered professionally with effective management of the medicine queues on E block.

4.80 Two patients a week were receiving detoxification therapy for alcohol withdrawal while on B wing (the reverse cohort unit, see Glossary), with the required 24-hour monitoring by nurses. Chelmsford was one of two prisons nationally piloting the use of buvidal (OST by depot injection), which had a promising start.

4.81 Four peer supporters were in post with four more being recruited. Vital mutual aid groups, such as Alcoholics Anonymous and Narcotics Anonymous, were due to return to the prison in September 2021, following the easing of COVID-19 restrictions.

4.82 Patients being released were offered opportunities to receive harm-minimisation advice, and naloxone (treatment to reverse the effects of opiate overdose) training and supplies, as necessary. They were assisted to engage with community agencies and to find pharmacies to continue OST, if needed.

Medicines optimisation and pharmacy services

4.83 Medicines were supplied by an in-house pharmacy. Pharmacy technicians were available seven days a week, but significant staff shortages had affected the provision of a comprehensive pharmacy service. Although pharmacy technicians should have been administering medicines across seven wings, the pharmacist and nurses from the mental health team sometimes had to cover the staffing deficits. Administration by a single member of staff meant they could not always adhere to the second check policy for controlled drugs. (See key concern and recommendation 1.38.)

4.84 There was a lack of senior pharmaceutical advice and support to make sure that standards of professional guidance and legislation were met. Prescription forms were stored securely, but there was no governance to make sure they were used appropriately.

4.85 There were delays in the prescribing or supply of some routine medicines, including those for the treatment of diabetes. No data for medicines reconciliation was provided so we were unable to assess how many new prisoners were seen by the pharmacy within 72 hours to make sure their medicines were continued where necessary. (See key concern and recommendation 1.38.)

4.86 An emergency cupboard provided access to urgent and critical medicines, but this was not always used; we saw delays in the administering of medicines, such as antibiotics, that were available in the emergency cupboard.

4.87 Prisoners had access to appropriate medicines to treat minor ailments, but there was inadequate monitoring of some prisoners on high-risk medicines.

4.88 The electronic records of administration were sometimes not completed thoroughly, which meant that it was not possible to tell whether patients had received their medicines or not.

4.89 Administration of medicines took place at 8am and 4pm. There were in-possession risk assessments for those administering their own medicines. Cell door administration was used for evening medicines that were required to be taken later than the 4pm administration, such as pain relief.

4.90 When patients did not collect or refused medication, this should have been followed up after two days. Pharmacy staff did refer some patients, but there was no evidence that action was taken on these occasions and this process was not covered in any operating procedure.

4.91 Regular local medicines management meetings made sure there was shared learning from medicines-related incidents, audits, shortages, alerts and recalls.

Dental services and oral health

4.92 Time for Teeth provided six dental sessions a week and emergency dental care had been available throughout the pandemic. The waiting time for routine appointments was around six months, but urgent appointments were arranged for the next clinic. The primary care nurses offered pain relief and made referrals to the dental team promptly. The dentist prescribed antibiotics in line with guidance and triaged patients effectively.

4.93 The dental team completed tooth extractions and other procedures, but were frustrated that they had not yet been allowed to undertake aerosol generating procedures (see Glossary), as uniformed staff did not have access to correct personal protective equipment (PPE) should they need to respond to an incident.

4.94 The dental clinic met infection control standards. Staff completed decontamination audits and equipment checks to make sure safety standards were met.

Recommendation

4.95 **The dental team should be able to provide a full range of treatments, including those involving aerosol generating procedures.**

Section 5 Purposeful activity

Prisoners are able and expected to engage in activity that is likely to benefit them.

Time out of cell

Expected outcomes: All prisoners have sufficient time out of cell (see Glossary of terms) and are encouraged to engage in activities which support their rehabilitation.

5.1 There was no current published regime which could describe adequately what prisoners could expect from their daily unlock routine. Staff seemed not to know and were inconsistent in the accounts they gave of when asked about a prisoners' entitlement (see key concern and recommendation 1.39). In our survey, only 36% of prisoners who said they knew what the lock-up times were supposed to be said these were usually kept to. One prisoner noted that:

> *'The regime needs greater consistency – we're never sure what time we will be opened/locked up and other areas such as kit change are inconsistent and other* [sic] *cancelled without notice.'*

5.2 Only 15% of prisoners were in full-time employment and they could spend up to seven hours a day out of their cell. However, over 16 months after the pandemic began, almost half the population were still unemployed and were locked in the cells for almost 23 hours a day. (See key concern and recommendation 1.39.) Many prisoners told us that this had had a detrimental impact on their well-being. In our survey, one prisoner wrote:

> *'The whole of G wing are not getting out of their cells enough to mix, and my mental health is at a breaking point. I get 30 minutes a week in the gym. I have been very lonely throughout the COVID-19 pandemic and was really frightened and it has left me unstable.'*

5.3 There was little creative use of peer workers to promote constructive activity. Only 30 such positions were filled and six prisoners held more than one, which limited opportunities for others to develop positive relationships with their peers and staff.

5.4 The library continued to be managed by Essex County Council and had a wide range of books, including audiobooks, DVDs and easy readers, as well as a reasonable range in foreign languages, although the one legal text for foreign national prisoners was out of date. The Reading Agency national charity had provided self-help material to address mental health and addiction concerns during the COVID-19 restrictions, which had been distributed free of charge to prisoners.

5.5 The library had only reopened at the start of the inspection. It had provided a remote ordering system for the previous 15 months, but this was not well promoted, and its use had been more limited then we have seen elsewhere. The librarian was committed to improving this and had distributed newsletters and promoted other positive initiatives, such as reading schemes and a video version of Storybook Dads, enabling prisoners to record a story for their children.

5.6 The gym had been closed for extended periods during the COVID-19 restrictions and did not fully reopen until June 2021. Physical education (PE) staff had been committed to engaging prisoners in physical activity during the restrictions by offering advice on in-cell activity and self-coping mechanisms but had been hampered by frequent redeployment to other areas. Since the facilities had reopened, PE staff had focused on offering an induction to all new arrivals and routinely visited each cell to make sure that all prisoners were offered access to PE at least weekly. At the time of our visit, up to 24 prisoners at a time were allowed to go to PE and this was to be increased to 36. Participation rates since reopening were consistently above 60%.

5.7 The PE facilities remained impressive and were appreciated by prisoners. The extensive range of equipment was being upgraded. Staffing shortfalls were being addressed and there were credible plans to reintroduce accredited learning once staff were in post. Links to the community through the Football Association Twinning Project had been re-established and were scheduled to commence as part of the prison's COVID-19 recovery plan.

Education, skills and work activities

This part of the report is written by Ofsted inspectors. From May 2021 Ofsted began carrying out progress monitoring visits to prisons to assess the progress that leaders and managers were making towards reinstating a full education, skills and work curriculum. The findings and recommendations arising from their visit are set out below.

5.8 Ofsted assessed that leaders were making reasonable progress towards ensuring that staff teach a full curriculum and provide support to meet prisoners' needs, including the provision of remote learning.

5.9 Prison leaders and managers had worked closely and quickly with the education provider during the national restrictions to make sure that prisoners had access to good-quality in-cell education, covering subjects such as English, mathematics, warehousing, construction, graphics, and painting and decorating. With the lifting of regime restrictions. HMPPS leaders and managers successfully put in place

plans to bring back the full curriculum in education, skills and work. This allowed small groups of prisoners to return to face-to-face teaching and instruction in almost all subject areas promptly. They prioritised prisoners with English as a second language and those who needed to complete English and mathematics courses.

5.10 Around a third of prisoners were able to work part time in workshops and industries. However, leaders recognised that they did not maximise the number of prisoners accessing the available places in education and skills. Attendance was often too low, and prisoners' punctuality was not always good. This was partly because the process to allocate prisoners to education or work was not fully effective. Too often, staff on the wings did not inform prisoners early enough about their allocated activity. As a result, prisoners were not always ready in time to attend.

5.11 Since the previous inspection and the relaxing of HMPPS restrictions, leaders had worked well to introduce new education courses. Prisoners completed new courses in food hygiene and had recently started a course in barbering. Extra courses in topics such as barista training were planned. However, the courses and work for vulnerable prisoners and those in the drug rehabilitation unit were limited. Leaders recognised that they needed to increase the education opportunities available to prisoners. They had begun useful and well-considered discussions with employers to develop accredited courses in the laundry and were planning more courses in construction. Leaders had thought carefully about their plans to increase the number of opportunities available in the workshops and in education once the COVID-19 restrictions were further lifted.

5.12 Tutors and instructors supported prisoners well to develop their skills and gain new knowledge. In painting and decorating, construction and graphics, prisoners developed good practical skills and understood how they could use these outside the prison. In carpentry, prisoners produced good-quality work. In plumbing, prisoners moved quickly from working with plastic pipes to compress and soldering joints correctly and safely. Since the easing of the restrictions, staff had awarded a large number of accredited qualifications to prisoners.

5.13 Most prisoners enjoyed their learning. Those who completed in-cell learning packs found them generally easy to follow. For example, in the roofing packs, information and assessment activities reinforced the practical learning prisoners had completed. In the suite of English packs, activities got incrementally more challenging for prisoners, which helped them develop their writing skills, for example. Tutors marked prisoners' work frequently and gave them useful feedback about how well they completed assessments. However, in a few instances, tutors did not give prisoners precise feedback on how they could improve their work, such as in grammar and punctuation.

5.14 The information, advice and guidance prisoners received at their induction were generally effective in making sure that most accessed appropriate learning. Prisoners had a reasonable understanding of the

opportunities available at the prison. However, the ongoing advice and guidance were not planned and developed well enough to help prisoners move on to their chosen next steps. As a result, they did not have clear plans to help them progress and access the most appropriate further learning or work.

5.15 The majority of prisoners felt well supported by staff. Staff supported prisoners on the two-week intensive roofing course successfully to gain employment. Staff helped a small number of prisoners to apply for Open University and distance learning courses. Tutors supported prisoners identified as needing extra help, such as those with dyslexia, appropriately. For example, tutors gave prisoners coloured overlays in classroom sessions. However, prisoners with more complex needs, such as autism, did not benefit from clear individualised support plans to help them.

Recommendations

5.16 **The number of available places in education, skills and work should be increased. Leaders should also improve attendance and punctuality.**

5.17 **Leaders and managers should ensure that all prisoners receive effective ongoing advice and guidance to direct them to the most appropriate learning and work activities.**

5.18 **Leaders and tutors should ensure that prisoners with complex additional learning needs have clear plans to support them to access learning and make good progress.**

Section 6 Rehabilitation and release planning

Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

Children and families and contact with the outside world

Expected outcomes: The prison supports prisoners' contact with their families and friends. Programmes aimed at developing parenting and relationship skills are facilitated by the prison. Prisoners not receiving visits are supported in other ways to establish or maintain family support.

6.1 Work to help prisoners maintain relationships with children and families was improving after the period of restrictions, although the pace of recovery was too slow. In our survey, only 18% of prisoners said staff had encouraged them to keep in touch with their family and friends.

6.2 The recently produced 'Families and significant others' strategy was comprehensive and informed by evidence from sources such as a prisoner survey on family contact and the reducing reoffending needs analysis. An action plan was managed through the 'Think families' meeting, attended by staff from a range of departments. The minutes indicated that the prison intended to make further improvements, such as family member involvement in assessment, care in custody and teamwork case management and challenge, support and intervention plans.

6.3 Social visits had resumed in June 2021, but there were too few sessions and they were only available from Monday to Thursday. The weekend provision previously available had been replaced by secure video calls (see Glossary). The arrangements for booking social visits were poor. All the visitors we spoke to said they had experienced significant delays in the telephone booking line, and we were also unable to get through, despite ringing 28 times.

6.4 Visitors told us that they had been treated with respect during the visit, but that sessions often started very late. While this lost time could be added on to the visit, this was not always convenient for those with deadlines to keep, such as childcare and parking times.

6.5 Staff from Ormiston Trust (see Glossary) worked in the visitors' centre and were highly regarded by visitors. The team had not yet resumed its previous monthly families' visit day or its parenting courses. There was no other structured family or parenting intervention or casework for prisoners.

6.6 In our survey, 91% of prisoners said they could use the phone every day, but we found some who did not have an in-cell phone and one prisoner who had not had one for a month.

Recommendation

6.7 **The social visits booking system should be easy to access.**

Reducing risk, rehabilitation and progression

Expected outcomes: Planning for a prisoner's release starts on their arrival at the prison. Each prisoner has an allocated case manager and a custody plan designed to address their specific needs, manage risk of harm and reduce the risk of reoffending.

6.8 A key function of the prison was to receive prisoners from court and transfer those serving longer sentences to other establishments. Since our previous inspection, there had been an increase in the proportion of unsentenced prisoners from just over 30% to almost 60%.

6.9 Management of reducing reoffending work had been neglected during 2020 but had improved this year. The prison had completed a needs analysis, using a variety of evidence sources. This analysis informed a comprehensive strategy and it was positive that the role of the offender management unit (OMU) in supporting this work was clearly articulated. The priorities identified in the strategy formed the basis of an action plan that was reviewed at the regular reducing reoffending meeting.

6.10 The head of reducing reoffending had also arranged several more frequent, less formal meetings to improve joint working and data sharing between teams, such as a fortnightly accommodation meeting with resettlement workers and the newly appointed accommodation support team. Teams who supported resettlement had returned to working in the prison's resettlement hub, although contact with prisoners was not yet routinely face to face.

6.11 The OMU was well resourced with the majority of prison offender managers (POMs) in post. The reduction in sentenced prisoners meant that caseloads were much lower than at the previous inspection. However, uniformed POMs were still being cross-deployed for three-quarters of the OMU time and their contact with prisoners was generally poor. Most of the prisoners we spoke to could not name their POM.

6.12 Prisoners assessed as high or very high risk of harm were usually allocated to probation officer POMs. In these cases, we found evidence of good contact with prisoners, and they spoke positively about their POM.

6.13 The prison had not yet resumed the full model of key working (see Glossary and paragraph 4.3), intended to supplement the work of

POMs and encourage prisoners to progress through their sentence in a positive way.

6.14 All new arrivals had a prompt assessment of their needs by the resettlement team. The initial resettlement plans were available to POMs and shared with community offender managers as appropriate. For unsentenced prisoners, this might be the only plan for their time in custody, so it was disappointing that resettlement plans were still not routinely completed face to face. In our survey, only 14% of prisoners said they had a custody plan.

6.15 Most eligible prisoners had an offender assessment system (OASYs) assessment and plans. All the sentence plans produced by POMs at Chelmsford that we reviewed were of reasonable quality, but we only saw evidence of progress against targets in about half of them.

6.16 Home detention curfew (HDC) arrangements were generally well managed and applications progressed promptly. However, some prisoners on lengthy periods on remand had already reached their HDC eligibility date by the time they were sentenced or had too little time to be released under these provisions. In the previous 12 months, about 38% of HDC releases were late, although the majority were for reasons outside the control of the prison, such as waiting for police checks.

Recommendation

6.17 **All eligible prisoners should receive regular, meaningful contact with prison offender managers.**

Public protection

6.18 Public protection arrangements were not robust, and areas of significant concern had persisted. (See key concern and recommendation 1.40.) At the previous inspection we found that the inter-departmental risk management team (IDRMT) had not met since the inspection before that in 2016; this time we found that the IDRMT was still not running and had not met since early 2020. This meant there was no clear oversight and audit of risk management measures in place for the release of the highest risk prisoners, in particular those subject to multi-agency public protection arrangements (MAPPA).

6.19 However, in the individual case file we reviewed, individual POMs generally managed the release of high-risk prisoners well, including discussion with community offender managers and, where appropriate, making sure that MAPPA levels were agreed in good time before the release date. The quality of POM documentation for MAPPA meetings in the community was also reasonably good.

6.20 Case administrators promptly identified new arrivals who posed a potential public protection risk and, where appropriate, made referrals for monitoring of mail and telephone calls, which were considered by POMs and authorised by an OMU manager. These processes were

completed promptly, the initial authorisations we reviewed were proportionate and the number of prisoners subject to monitoring was not excessive. Other departments, such as visits and censors, were regularly informed of individuals who were subject to restrictions and monitoring. However, monitoring of calls was not up to date and some had not been listened to for many weeks. In one case, a POM had recommended that monitoring should cease as there was no evidence the prisoner was using the phone inappropriately, unaware that no calls had been listened to since the initial authorisation. (See key concern and recommendation 1.40.)

Categorisation and transfers

6.21 Once sentenced, prisoners were quickly allocated a security category and generally moved promptly to another establishment to serve their sentence. In the previous year, over 750 prisoners were transferred and the average length of stay during this time was 56 days.

6.22 About half of transfers were to a training prison where prisoners had the opportunity to engage with offending behaviour work to support their rehabilitation. However, some category B training prisons had refused transfers without good cause, citing reasons such as the prisoner having recently been in segregation or under ACCT case management for those at risk of suicide or self-harm.

6.23 There was a similar issue with prisoners convicted of a sexual offence as some other specialist prisons would only accept those with more than 16 months left to serve. This meant some of these prisoners were left to serve out their sentence at Chelmsford without the opportunity of completing offending behaviour work.

6.24 Prisoners given category D status often had to wait too long to transfer to open conditions. Three of the 16 category D prisoners at Chelmsford at the time of the inspection were still waiting for a place in an open prison four months after being approved.

6.25 The use of transfer holds was not routinely monitored and at the time of the inspection 71 prisoners were subject to a hold, some of which were no longer relevant. The prison responded quickly to this issue and reviewed all holds in place.

Recommendation

6.26 **HMPPS should make sure that prisoners can move to the most appropriate prison without delay.**

Interventions

Expected outcomes: Prisoners are able to access interventions designed to promote successful rehabilitation.

6.27 As a local prison, Chelmsford was not resourced to provide accredited offending behaviour programmes. At the previous inspection, we reported on a range of non-accredited interventions, some delivered by partner agencies, covering areas such as team building, restorative justice and thinking skills. It was disappointing that these interventions were no longer available.

6.28 Through the period of COVID-19 restrictions the resettlement team had provided prisoners with a range of in-cell workbooks, including some focused on personal development. However, following the recent reunification of resettlement teams with the National Probation Service they were no longer able to support this provision.

6.29 The regional psychology team worked individually with a small number of prisoners who were not suitable for, or would not engage with, offending behaviour programmes.

6.30 While prison officer POMs could access a wide range of off-the-shelf guides for working with prisoners with different offending behaviour needs, none of the team had completed more specialist training to work with prisoners convicted of sexual offences or in delivering work to address domestic violence.

6.31 Work to support prisoners with finance, benefit and debt needs was now limited, with the previous money management courses no longer available. While the resettlement team continued to help prisoners open a bank account, they could no longer help them obtain identification documents.

Recommendation

6.32 **Prisoners who stay at Chelmsford throughout their sentence should be able to access a range of offence-focused work.**

Release planning

Expected outcomes: The specific reintegration needs of individual prisoners are met through an individual multi-agency plan to maximise the likelihood of successful reintegration into the community.

6.33 About 80 prisoners a month had been released in the previous 12 months. However, the level of ongoing resettlement support was limited. In our survey, only 35% of those due for release said someone was helping them to prepare.

6.34 Staff from resettlement, Forward Trust (information, advice and guidance service) and Department for Work and Pensions were based in the prison's resettlement hub. However, recovery from the COVID-19 restrictions had been slow. Face-to-face support was not yet routine and prisoners were no longer able to drop in informally at the hub to access additional support and discuss their resettlement plans.

6.35 In our survey, although many of those who expected to be released in the next three months said they needed support with getting employment (70%), sorting out finances (55%) and finding accommodation (61%), only 14% said they were getting help with finding employment, only 13% with sorting out finances and only 5% with finding accommodation.

6.36 We were told that almost a fifth of prisoners had been released without an address to go to in 2021 to date, but monitoring of the extent of this problem was poor and data were contradictory, which made it difficult to establish the true extent of the problem.

6.37 Work was ongoing to offer a facility just outside of the prison for prisoners to go to on release to receive further advice and support. However, practical release arrangements were currently limited and not as well developed as we often see in other local prisons.

Section 7 Recommendations in this report

The following is a list of repeated and new concerns and recommendations in this report.

Key concerns and recommendations

7.1 Key concern 1.33: 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. Levels of violence remained among the highest of all local prisons since 2018. Analysis of data was poor, preventing a deeper understanding of risks, so it was unsurprising that plans to tackle violence and improve outcomes were limited or non-existent. The lack of accountability over staff manifested itself in an over-reliance on the small safer custody team, whose work was given insufficient priority, and in the failure of other staff and senior leaders to take responsibility.

Recommendation: Levels of violence should be reduced significantly so that prisoners feel safe. All staff should be clearly committed to reducing violence. Good data analysis should underpin this progress by providing a better understanding of the risks and required actions.
(To the governor)

7.2 Key concern 1.34: Evidence showed that the supply of drugs remained a key threat to safety and the health of prisoners at Chelmsford. Despite efforts to reduce this there were some gaps in the approach. For example, drug testing was not taking place and the body scanner was not used to full effect.

Recommendation: Drug supply should be reduced further through the delivery of an effective strategy and action plan which makes use of all the available methods including increasing the use of the body scanner and restarting drug testing for prisoners.
(To the governor)

7.3 Key concern 1.35: 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 and this is the fourth consecutive inspection where we have reported significant increases in the rate of self-harm. We found that the Listener scheme had stalled and there were many weaknesses in the ACCT and other preventative processes. There were further failings in night safety procedures, delays in responding to cell bells and a lacklustre approach to data, learning and action planning.

Recommendation: Work to prevent suicide or self-harm should be improved significantly. The use of Listeners, ACCT case management and other preventative measures should be delivered proactively and robustly. Data analysis, learning and action planning should support the delivery of improved outcomes for prisoners.
(To the governor)

7.4 Key concern 1.36: Prisoners experienced real frustrations in getting anything done. 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 prisoners with disabilities and mental health problems. A dominant staff culture, which we describe as negative and damaging, led to the failure to support or promote safety, decency or rehabilitation among prisoners. Too many staff were dismissive in their dealings with prisoners or evidenced only limited empathy for those for whom they were responsible. A lack of accountability and management oversight of staff enabled poor practice to go unchallenged and in our staff survey, too few felt that managers set high standards of behaviour.

Recommendation: Prisoners' perceptions of their treatment should be improved. Staff must have higher expectations of prisoners and take personal responsibility for the promotion of safety, decency and rehabilitation. Staff should engage constructively with prisoners, respond positively to their reasonable requests and managers should hold them to account.
(To the governor)

7.5 Key concern 1.37: Many cells were cramped, in poor repair and grubby, and those on the first night unit remained poorly prepared. Many cells were graffitied and had inadequate furniture, and there was a shortage of pillows, decent mattresses and kettles. Many shared cells had no toilet screening and some toilet seats and lids were broken. The infestation of rats persisted on some wings and in serveries, and rubbish had been allowed to accumulate in some areas which only served to exacerbate this problem.

Recommendation: Prisoners should live in a clean and decent environment that is in a good state of repair and fit for purpose.
(To the governor)

7.6 Key concern 1.38: Significant staff shortages in health care, particularly in the mental health and pharmacy teams, had affected the delivery of services. Many prisoners had experienced delays in receiving their medication, which was detrimental to their care, and some aspects of medicines management was unsafe. There was an over-reliance on agency staff, particularly in the mental health team, which meant that service continuity could not be guaranteed. There were still weaknesses in partnership working between the prison and the health service, with inconsistent officer support to manage medicine

administration effectively and enable clinics to run efficiently, and too frequent cancellations of external hospital appointments.

Recommendation: The health needs of prisoners should be fully met and the management of medicines should be safe. Prisoners should be able to attend all their clinical appointments.
(To the governor and the healthcare provider)

7.7 Key concern 1.39: Many prisoners were locked in their cell for almost 23 hours a day, with an inevitable toll on their well-being. This reflected in part the COVID-19 restrictions but even in 2018 when we last inspected, we found many prisoners locked in cell for 22 hours day. Plans to introduce a meaningful regime were limited and being implemented far too slowly.

Recommendation: Prisoners should have regular and predictable time out of cell, which is sufficient to promote rehabilitation and mental well-being.
(To the governor)

7.8 Key concern 1.40: Public protection arrangements were not robust. The inter-departmental risk management team had not met since early 2020, leaving no clear oversight and audit of risk management arrangements for the release of prisoners posing the highest risk, including those managed under multi-agency public protection arrangements (MAPPA). There was a backlog of phone calls waiting to be monitored for public protection concerns, which presented further gaps in risk management.

Recommendation: Public protection measures and oversight to manage those presenting a risk of serious harm should be applied robustly.
(To the governor)

Recommendations

7.9 Recommendation 4.10: Calls using cell bells should be responded to promptly.
(To the governor)

7.10 Recommendation 4.15: Prisoners should be served food of good quality and sufficient quantity.
(To the governor)

7.11 Recommendation 4.20: The prison should maintain effective and timely applications and complaints systems that are subject to robust quality assurance.
(To the governor)

7.12 Recommendation 4.25: Outcomes for prisoners in protected groups should be improved through the implementation of a comprehensive strategy that is informed by consultation and effective analysis of data.
(To the governor)

7.13 Recommendation 4.33: Professional telephone interpretation should always be used when necessary.
(To the governor)

7.14 Recommendation 4.48: Responses to health complaints should address the issues highlighted and inform prisoners about how to escalate their complaint if they are unhappy with the response.
(To the governor)

7.15 Recommendation 4.49: There should be refresher training for officers on the use of codes for medical emergencies.
(To the governor)

7.16 Recommendation 4.75: Accurate data on transfers to mental health facilities should be used to analyse trends and demonstrate actions taken to make sure that patients do not wait too long for a transfer.
(To the governor)

7.17 Recommendation 4.95: The dental team should be able to provide a full range of treatments, including those involving aerosol generating procedures.
(To the governor)

7.18 Recommendation 5.16: The number of available places in education, skills and work should be increased. Leaders should also improve attendance and punctuality.
(To the governor)

7.19 Recommendation 5.17: Leaders and managers should ensure that all prisoners receive effective ongoing advice and guidance to direct them to the most appropriate learning and work activities.
(To the governor)

7.20 Recommendation 5.18: Leaders and tutors should ensure that prisoners with complex additional learning needs have clear plans to support them to access learning and make good progress.
(To the governor)

7.21 Recommendation 6.7: The social visits booking system should be easy to access.
(To the governor)

7.22 Recommendation 6.17: All eligible prisoners should receive regular, meaningful contact with prison offender managers.
(To the governor)

7.23 Recommendation 6.26: HMPPS should make sure that prisoners can move to the most appropriate prison without delay.
(To HMPPS)

7.24 Recommendation 6.32: Prisoners who stay at Chelmsford throughout their sentence should be able to access a range of offence-focused work.
(To the governor)

Section 8 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy prison. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2018, support during prisoners' early days at the prison was adequate. Levels of violence were very high and not enough was being done to address the underlying causes. The number of adjudications was high. Force was used very frequently. The segregation environment was poor, but staff-prisoner relationships were good. Security arrangements were generally appropriate and focused on the challenges, but drug use was very high. There had been many self-inflicted deaths over recent years, and some serious issues were recurring. Levels of self-harm were extremely high, as was the use of constant supervision. Not enough was being done to provide appropriate support. Adult safeguarding arrangements were reasonably well developed. Outcomes for prisoners were poor against this healthy prison test.

Key recommendations

Managers should work proactively to reduce levels of violence and develop and embed a range of initiatives to address the problem. (S38)
Not achieved

Managers should invest in staff, processes, resources and technology to help reduce the drug supply into the prison. (S39)
Partially achieved

Managers should improve the care staff provide to men who were at risk of self-harm and there should be a better focus on the issues raised by the PPO in relation to deaths in custody. (S40)
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2018, staff-prisoner relationships were generally respectful, and the key worker initiative was welcome. Most men had a member of staff to support them. Many staff were new and needed more mentoring to develop their confidence and skills. Cleanliness was poor and graffiti widespread. The older living accommodation was particularly poor and many routine maintenance jobs had not been completed. Men faced many frustrations in their everyday lives. Consultation with prisoners was underdeveloped and the applications and complaints processes needed urgent attention. Equality and diversity work were also underdeveloped, but those with protected characteristics were mainly concerned about the same issues as other men. Faith provision was strong. Important aspects of health care leadership and care required improvement. Substance misuse support now met most men's needs. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

Managers should ensure prisoners are held in clean and respectful living conditions. (S41)
Not achieved

Managers should ensure there are clear and effective processes so prisoners can be consulted, make requests and resolve issues. (S42)
Not achieved

Robust governance structures, including consistent and competent health staff, effective leadership and improved partnership working between the prison and health providers, should ensure health provision consistently meets the needs of prisoners. (S43)
Partially achieved

Purposeful activity

Prisoners are able, and expected, to engage in activity that is likely to benefit them.

At the last inspection, in 2018, time out of cell was severely restricted because of ongoing staffing issues. Many men had very limited time out of cell and extended periods of lock-up, which added to their frustrations. The library and gym were reasonably good. Ofsted found education, skills and work required improvement. There remained insufficient activity places, and attendance and punctuality were poor. Too much teaching and learning needed to improve but mentors were well used. More activities needed to be accredited. Outcomes were good if men completed an activity, but many did not. Outcomes for prisoners were poor against this healthy prison test.

Key recommendations

Time out of cell should be improved and adhere to the published regime. Men should have at least an hour's exercise outside every day. (S44)
Not achieved

Men should have at least an hour's exercise outside every day. (S44)
Not achieved

Managers should ensure that there are sufficient activity places and that attendance, accreditation and the recognition of prisoners' progress are improved. (S45)
Not assessed at this inspection

Rehabilitation and release planning

Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.

At the last inspection, in 2018, children and families provision was reasonably good. The strategic focus on supporting rehabilitation was developing. Nearly all men had an up-to-date offender assessment system (OASys) report and good offender management work was being undertaken with high risk men. Support for medium and low risk men was adequate. Public protection arrangements were generally appropriate but the inter-departmental risk management team (IDRMT) needed to be embedded. Most men progressed quickly to other prisons and the home detention curfew (HDC) process had improved. A reasonable range of resettlement interventions were offered, although they needed to be better coordinated. Weaknesses in release planning processes meant not all men were properly assessed. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendation

Managers should ensure that men have their resettlement needs assessed on arrival and prior to release, and that offender management arrangements meet the needs of all eligible groups. (S46)
Not achieved

Appendix I About our inspections and reports

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

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

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this Inspectorate's thematic review Suicide is everyone's concern, published in 1999. For men's prisons the tests are:

Safety
Prisoners, particularly the most vulnerable, are held safely.

Respect
Prisoners are treated with respect for their human dignity.

Purposeful activity
Prisoners are able, and expected, to engage in activity that is likely to to benefit them.

Rehabilitation and release planning
Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release into the community.

Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by Her Majesty's Prison and Probation Service (HMPPS).

Outcomes for prisoners are good.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

Outcomes for prisoners are reasonably good.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

Outcomes for prisoners are not sufficiently good.
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

Outcomes for prisoners are poor.
There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

Our assessments might result in one of the following:

Key concerns and recommendations: identify the issues of most importance to improving outcomes for prisoners and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of prisoners.

Recommendations: will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections.

Examples of notable positive practice: innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

Five key sources of evidence are used by inspectors: observation; prisoner and staff surveys; discussions with prisoners; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection.

All inspections of prisons are conducted jointly with Ofsted or Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council (GPhC). Some are also conducted with HM Inspectorate of Probation. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

This report

This report provides a summary of our inspection findings against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 5, 2017) (available on

our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/). The reference numbers at the end of some recommendations indicate that they are repeated and provide the paragraph location of the previous recommendation in the last report. Section 7 lists all recommendations made in the report. Section 8 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of prisoners and a detailed description of the survey methodology can be found on our website (see Appendix IV: Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Martin Lomas	Deputy Chief inspector
Sandra Fieldhouse	Team leader
Ian Dickens	Inspector
Martyn Griffiths	Inspector
Sumayyah Hassam	Inspector
Deri Hughes-Roberts	Inspector
David Owens	Inspector
Tamara Pattinson	Inspector
Annie Bunce	Researcher
Amilcar Johnson	Researcher
Catherine Shaw	Researcher
Jed Waghorn	Researcher
Maureen Jamieson	Lead health and social care inspector
Paul Tarbuck	Health and social care inspector
Anne Melrose	Pharmacist
Lynda Day	Care Quality Commission inspector
Dayni Johnson	Care Quality Commission inspector
Jane Hughes	Ofsted inspector
Steve Lambert	Ofsted inspector

Appendix II Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Aerosol generating procedures
Certain medical and patient care activities that can result in the release of airborne particles (aerosols), and a risk of airborne-transmission of infections that are usually only spread by droplet transmission.

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

Certified normal accommodation (CNA) and operational capacity
Baseline CNA is the sum total of all certified accommodation in an establishment except cells in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged cells, cells affected by building works, and cells taken out of use due to staff shortages. Operational capacity is the total number of prisoners that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

Challenge, support and intervention plan (CSIP)
Used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence.

Key worker scheme
The key worker scheme operates across the closed male estate and is one element of the Offender Management in Custody (OMiC) model. All prison officers have a caseload of around six prisoners. The aim is to enable staff to develop constructive, motivational relationships with prisoners, which can support and encourage them to work towards positive rehabilitative goals.

Leader
In this report the term ‘leader’ refers to anyone with leadership or management responsibility in the prison system. We will direct our narrative at the level of leadership which has the most capacity to influence a particular outcome.

Offender Management in Custody (OMiC)
The OMiC model, being rolled out across the closed male prison estate, entails prison officers undertaking key work sessions with prisoners (implemented during 2018–19) and case management, which established the role of the prison offender manager (POM) from 1 October 2019.

Ormiston Trust
A charitable organisation working to promote contact with children and families for those in prison.

Personal protective equipment (PPE)
Safety equipment including masks, aprons and gloves, worn by frontline workers during the COVID-19 pandemic.

Protected characteristics
The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

Protection of adults at risk
Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

Recovery plan
Recovery plans are published by HMPPS and aim to ensure consistency in decision-making by governors, by setting out the requirements that must be met for prisons to move from the most restricted regime to the least as they ease COVID-19 restrictions. (https://www.gov.uk/government/publications/covid-19-national-framework-for-prison-regimes-and-services)

Reverse cohort unit (RCU)
Unit where newly arrived prisoners are held in quarantine for between seven and 10 days.

Secure video calls
A system, commissioned by HMPPS, that requires users to download an app to their phone or computer. Before a visit can be booked, users must upload valid ID.

Social care package
A level of personal care to address needs identified following a social needs assessment undertaken by the local authority (i.e. assistance with washing, bathing, toileting, activities of daily living etc., but not medical care).

Time out of cell
Time out of cell, in addition to formal 'purposeful activity', includes any time prisoners are out of their cells to associate or use communal facilities to take showers or make telephone calls.

Urgent Notification
A process launched by HMI Prisons when inspectors are particularly concerned about outcomes for detainees. The Chief Inspector writes to the Secretary of State for Justice, who is expected to respond within 28 calendar days with an action plan for how the establishment will address the concerns along with a target date for completion.
https://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/urgent-notifications/

Appendix III Care Quality Commission Requirement Notice

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

The inspection of health services at HMP Chelmsford was jointly undertaken by the CQC and HMI Prisons under a memorandum of understanding agreement between the agencies (see https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/working-with-partners/). The Care Quality Commission issued 'requirement to improve' notices following this inspection.

Requirement Notices

Provider

HGRG Medical Services Limited

Location

HMP Chelmsford

Location ID

1-10054240345

Regulated activities

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

Action we have told the provider to take

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

Regulation 12 (1)(g)

Care and treatment must be provided in a safe way for service users and the proper and safe management of medicines to ensure compliance with the

requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met

There were delays in the prescribing and or the supply of some routine medicines. Staff did not always adhere to the second checking procedures for controlled drugs. Staff were not always consistent in how they reported medicine administration.

There were delays in the prescribing or supply of some prisoners' routine medicines including those for the treatment of diabetes.

For example, one patient had a three-day delay before being given their prescribed antibiotics, despite these being available in the out of hours medication stock. Out of 12 patient records we reviewed, we found nine examples where nine patients were not provided with routine medicine/s.

Staff did not always adhere to the second checking procedures for controlled drugs. We found on several occasions and at the time of inspection, that there was not always a member of staff available to second check the administration of Controlled Drugs.

The electronic records of administration were sometimes not completed thoroughly which meant it was unable to assess whether prisoners had received their medicines or not.

The medicine administration codes staff used, varied and did not provide clear evidence to demonstrate prisoners had had their required medicines. For example, using terms such as 'missed', 'not available' or 'unable to administer'.

Regulation 17 (1)(2)(b) and (c)

Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met

Data to show how many prisoners were provided with a medicine review within 72 hours of their arrival was not available. There were no governance processes in place to ensure the management of FP10 were safe. There were limited processes in place to ensure patients who missed medication were safe and were followed up.

There was no data available for medicines reconciliation, so we were unable to assess how many prisoners were seen by pharmacy within 72 hours to ensure medicines were continued where necessary.

Medicines-related stationery (FP10s) were stored securely but there were no governance processes in place to ensure these were used appropriately and to minimise the risk of diversion.

There were limited processes in place to ensured staff knew how to accurately complete patient records for medicine administration. There was a lack of oversight to identify and follow up on prisoners who may have missed medicines.

Appendix IV Further resources

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

Urgent Notification and Secretary of State's response

We issued an Urgent Notification letter and inspection debriefing paper on 26 August 2021. The Secretary of State responded with a letter and action plan.

Prison population profile

We request a population profile from each prison as part of the information we gather during our inspection. We have published this breakdown on our website.

Prisoner survey methodology and results

A representative survey of prisoners is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

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