Report on an independent review of progress at

HMP Belmarsh

by HM Chief Inspector of Prisons

11–13 April 2022

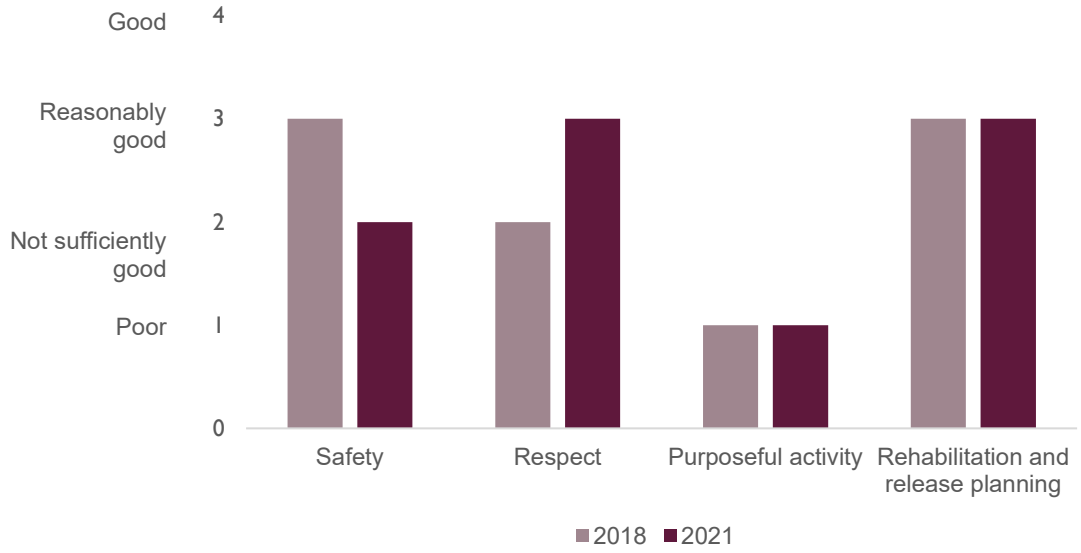
Contents

Section 1 Chief Inspector's summary

1.1 HMP Belmarsh is a high-security prison in south-east London that held approximately 660 prisoners at the time of our inspection, most of whom were unsentenced. It is one of 13 long term and high security prisons, but the only reception prison in the high security estate. It also operates a high secure unit (HSU) for prisoners presenting the very highest risk of escape.

1.2 At our previous inspections of HMP Belmarsh in 2018 and 2021, we made the following judgements about outcomes for prisoners.

Figure 1: HMP Belmarsh healthy prison outcomes in 2018 and 2021



1.3 At the full inspection in July-August 2021, staff-prisoner relationships had improved, health care was good, and the prison was calm and well-ordered. Safety had deteriorated, however: the rate of violence was high, use of force had increased and there was insufficient attention to the growing level of self-harm. There was largely inadequate use of data to support the development of effective strategies for safety or equality, and leadership oversight of these areas lacked rigour and focus. A major concern was that, notwithstanding the undoubted challenges of the pandemic, not enough had been done to increase the level of purposeful activity for prisoners who remained locked up for very long periods each day.

1.4 During this independent review of progress, we examined 10 key recommendations, and our colleagues in Ofsted addressed progress against three themes. It was clear that leaders had taken the report of the inspection seriously and, in most areas, our findings were encouraging, with reasonable progress found against most recommendations.

1.5 The governance of use of force and violence were much better and there was some early evidence of improving outcomes. Violence and self-harm had reduced and we saw some good initiatives, for example, a conflict resolution team interviewed every new arrival to identify concerns and minimise potential clashes. There had been very little progress, however, in increasing the effective use of body-worn cameras and a different approach by leadership was clearly required.

1.6 Constant supervision arrangements for prisoners at risk of self-harm were improving and there were now enough Listeners (see Glossary) for the population. Assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm was also used more effectively to support those in crisis, but it was still implemented inconsistently and reviews were often not multidisciplinary.

1.7 The equality and diversity strategy had been updated and there was good progress against many of the priorities set out in the equality action plan. The diversity and inclusion meeting had just restarted and was more focused than it had been, but it was too early to assess its effectiveness in achieving positive change.

1.8 Data were being gathered and used more effectively in several areas, but there was still a considerable distance to travel to make sure they were consistently informing improvement planning. For example, we were surprised to find that leaders could not tell us how many prisoners were engaged in activities on any given day, or how frequently individual prisoners were in activity.

1.9 There had been some improvement to time out of cell and purposeful activity from a low base. We were told that most prisoners were now engaged in some form of purposeful activity, the gym and library had reopened, and corporate worship and social visits had resumed. However, too many prisoners still spent very long periods locked behind their doors with little to do. Leaders were planning to increase activities further, but there was no timetable for this and it remained unclear when the improvements would be seen.

1.10 Rehabilitation and release planning had been a generally positive area at the full inspection with the significant exceptions of poor resettlement support for the large population of unsentenced prisoners, and inadequate public protection phone monitoring. It was a concern that we saw no meaningful progress in either of these areas and there was no clear plan to address the identified problems.

1.11 Overall, there had been encouraging progress towards meeting most of our recommendations, although there were a few exceptions, and in some areas the advances were recent and fragile.

Charlie Taylor
HM Chief Inspector of Prisons
April 2022

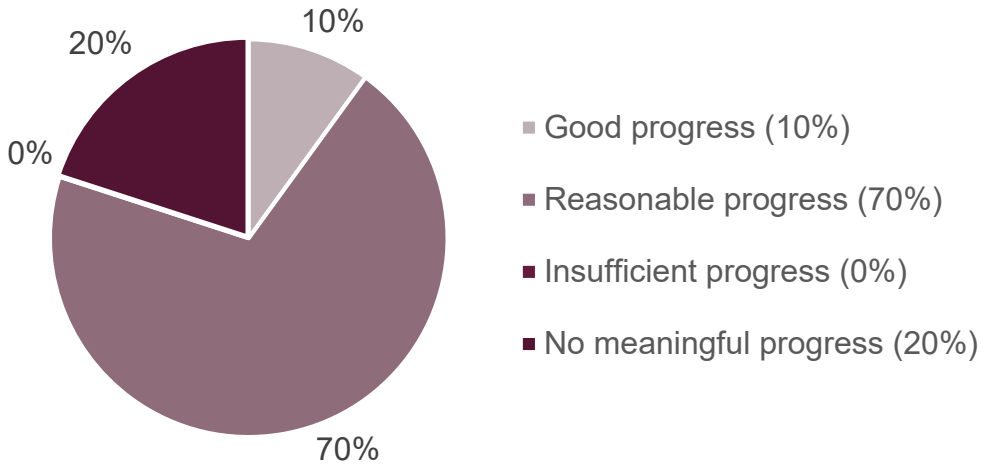
Section 2 Key findings

2.1 At this IRP visit, we followed up 10 recommendations from our most recent inspection in August 2021 and Ofsted followed up three themes based on their latest inspection or progress monitoring visit to the prison, whichever was most recent.

2.2 HMI Prisons judged that there was good progress in one recommendation, reasonable progress in seven recommendations and no meaningful progress in two recommendations; there was insufficient progress in none.

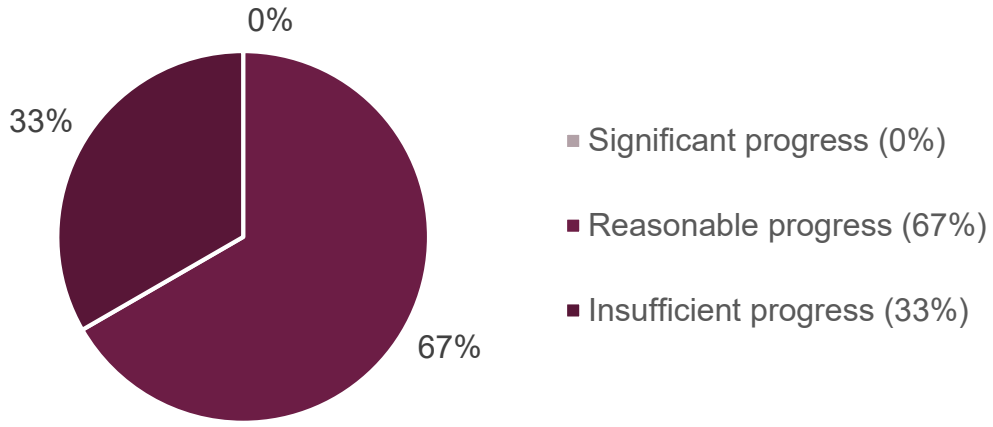
Figure 2: Progress on HMI Prisons recommendations from 2021 inspection (n=10)

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



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

Figure 3: Progress on Ofsted themes from 2021 inspection (n=3).



Notable positive practice

2.4 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.

2.5 Inspectors found one example of notable positive practice during this independent review of progress.

2.6 The conflict resolution team, which was part of the safer custody function, interviewed every prisoner on arrival to identify concerns and help make sure that suitable actions were taken to reduce the risk of violence between prisoners. The team maintained a list which tracked all known conflicts, including those involving known gang members. (See paragraph 3.5.)

Section 3 Progress against the key concerns and recommendations and Ofsted themes

The following provides a brief description of our findings in relation to each recommendation followed up from the full inspection in 2021. The reference numbers at the end of each recommendation refer to the paragraph location in the full inspection report.

Early days in custody

Concern: In our survey, only 27% of prisoners said that they could speak to a Listener on their first night. Although some orderlies on the first night centre were Listeners, this was not their core duty and they did not offer a listening service to new arrivals. Instead they provided a functional role issuing paperwork and making tea. There was no routine opportunity for new arrivals to discuss any immediate anxieties with an officer in private on their first night.

Recommendation: Listeners should be able to carry out their role throughout the reception, first night and induction processes. (3.13)

3.1 There were now 30 trained Listeners in the prison, including three who worked full-time on reception and seven on the house block with the first night centre. Listeners in reception worked full time from 9am until around 8pm, and those on the first night centre were available at all times. During induction, Listeners were available to answer prisoners' questions and provided and explained an information leaflet and induction booklet (in several languages), which contained useful information about life in the prison.

3.2 Listeners and staff told us that there had not been any problems recently with facilitating access to Listeners during new arrivals' reception or early days.

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

Encouraging positive behaviour

Concern: Levels of violence had continued to increase since the last inspection and too many prisoners felt unsafe. Despite available prison data, leaders did not analyse the indicators of violence in detail. The prison's strategy and associated action plan did not reflect the risks it faced and there had been no formal strategic meeting to address violence for over 18 months.

Recommendation: Safety data should be used to inform a strategy and action plan to reduce increasing levels of violence, which leaders monitor and drive effectively. (1.38)

3.4 The level of recorded violence in the previous six months had reduced compared to the same period before the inspection. The violence reduction strategy had been updated and, since January 2022, safety data were being collated to inform its future development. However, not enough data were yet available to inform a tailored approach that fully reflected the prison's specific characteristics.

3.5 The violence reduction action plan had suitable objectives, although outstanding actions did not have target completion dates. Leaders had already implemented some useful initiatives, which were having an early impact in reducing violence. For example, members of the conflict resolution team, part of safer custody, interviewed every new arrival to identify concerns and make sure that suitable actions were taken to reduce the risk of violence. They maintained a list that tracked all known conflicts, including those involving identified gang members. Trained peer workers had also been appointed to liaise with the conflict resolution team and support efforts at mediation.

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

Use of force

Concern: Governance of use of force had lapsed. Most incidents were spontaneous, but staff did not routinely activate body-worn video cameras. Despite good local data, there was no effective analysis or detailed scrutiny of force to make sure that incidents were necessary, justified and proportionate.

Recommendation: There should be robust scrutiny of the use of force, including data, camera footage and staff statements, to make sure that force is necessary, justified and proportionate. (1.39)

3.7 A weekly use of force scrutiny meeting had been introduced three months previously to scrutinise paperwork and footage of incidents. Attendance was good and included representatives from psychology, the Independent Monitoring Board, health care and the equality team. The meeting reviewed at least 20% of all incidents and data were used well to target scrutiny efforts. For example, evidence of disproportionate use of force on young adults and black and minority ethnic prisoners had led to the decision to also review all force used on these groups.

3.8 In the video footage and documentation we reviewed that had also been scrutinised by managers, our findings were similar to those of the review meeting. Concerns identified were referred to the deputy

governor for further investigation and appropriate action had been taken in each case.

3.9 There had, however, been little progress in increasing the effective use of body-worn cameras. Although they were available, staff still did not activate them routinely or early enough to record the entire incident. In the previous three months, there had been 132 uses of force; body-worn cameras had been turned on in 56 incidents but recorded the entire event in only 13 cases. Managers had tried to promote the use of the cameras, but the approach taken so far had clearly been unsuccessful.

3.10 The prison had made reasonable progress against this recommendation.

Suicide and self-harm prevention

Concern: The quality of case management support for prisoners at risk of suicide and self-harm was weak: risk was not always assessed correctly; some case reviews were too infrequent; and care plans were missing or poorly completed. Records of prisoners' interactions were often missing. It was clear that staff had struggled to implement the new version of ACCT.

Recommendation: Prisoners at risk of suicide and self-harm should receive additional support through the use of good quality assessment, care in custody and teamwork (ACCT) case management that includes an accurate assessment of their risk, sufficiently frequent case reviews, appropriate support actions recorded in a care plan and a consistent record of their daily interactions. (1.40)

3.11 Since the inspection, the rate of self-harm had been gradually reducing and was much lower than similar prisons. The weekly safety intervention meeting provided regular overview of prisoners being supported through ACCT case management.

3.12 The prison regularly considered data on self-harm, for example, identifying that in the previous six months four individuals were responsible for 38% of all incidents. However, it had not yet conducted a detailed analysis to understand the underlying reasons for self-harm or developed a defined strategy to address these.

3.13 The recently appointed head of safety had identified priority actions to improve the quality of support for prisoners on ACCT. This included a revised assurance process that had identified areas for improvement.

3.14 We saw some evidence of progress in the ACCT documents we reviewed; for example, case reviews now mostly took place when scheduled and the overall quality of the documents was better than at the inspection. However, attendance at reviews remained limited, with little evidence of input from other departments, and care plans often still had too little detail.

3.15 The prison regularly circulated a timetable of reviews scheduled for prisoners being supported by ACCT. This gave staff who worked in other areas the opportunity to identify prisoners who they may be working with or have knowledge of, and volunteer to attend the prisoner's review.

3.16 Managers intended to undertake a formal staff training needs analysis for ACCT. In the meantime, a custodial manager from the safer custody team attended the house blocks to offer ad-hoc upskilling sessions to staff and delivered sessions on ACCT management during monthly staff training days. Several notices to staff also highlighted areas of ACCT management that needed improvement.

3.17 The prison had made reasonable progress against this recommendation.

Suicide and self-harm prevention

Concern: Constant supervision arrangements for prisoners at the highest risk of suicide and self-harm were unsafe. Staff read newspapers rather than observing the prisoners, who were also sometimes left unsupervised and unobserved. Supervising staff worked long shifts, which affected their concentration, and they did little to encourage prisoner interaction and participation in anything purposeful.

Recommendation: Constant supervision arrangements should keep prisoners at risk safe and encourage them to engage with a purposeful regime wherever possible. (1.41)

3.18 In the previous six months, 22 prisoners had been subject to constant supervision and all but one had been placed in the constant watch cells in the health care department.

3.19 Staff performed constant supervision on 12-hour shifts but now had two mandatory 30-minute breaks, although this was still a long time to retain concentration without fatigue. They received briefing information, which included suggestions to engage with the prisoners and keep them occupied. Medical staff also produce detailed risk assessments to help staff understand the most complex cases.

3.20 We saw some examples where prisoners under constant supervision had been encouraged to engage with purposeful activity. In one case, a prisoner employed as a cleaner in the health care department had been able to complete this duty while he was under constant supervision. However, we also spoke to a prisoner who had asked for education input but only received one education pack a week, which he said he was able to complete within half an hour.

3.21 We observed and spoke to staff performing constant supervision who were attentive. They told us they regularly spoke with the prisoners they were supervising, and the prisoner we were able to speak to also reported that staff spoke with him.

3.22 The prison had recognised that monitoring arrangements could be enhanced by installing CCTV in the area of the constant watch cells. Funding for this had been approved but the installation had not yet started.

3.23 The prison had made reasonable progress against this recommendation.

Protection of adults at risk (see Glossary)

Concern: Although an adult safeguarding policy had been developed, this had not been implemented and there were still no processes when we visited. It was unclear which manager currently held responsibility for this work and there was no record of any prisoners who had been identified as needing additional protection, nor any associated referrals. Leaders did not currently attend the local safeguarding adults board. Wing staff had not been trained to identify prisoners who were at risk of being easily exploited or abused.

Recommendation: Prisoners defined as adults at risk of harm, abuse and neglect should be systematically identified and protected. (3.60)

3.24 The prison's safeguarding policy had recently been reviewed and updated, and was now more suited to the prison context.

3.25 Efforts to identify prisoners who were at risk of harm had been strengthened. In addition to the standard induction, members of the safety team now spoke to all new arrivals in their first few days to identify any vulnerabilities or unmet needs. Those identified as being of concern could be referred to the safety intervention meeting for discussion, and we saw evidence of this happening on several occasions.

3.26 Nineteen prisoners were receiving social care support at the time of our visit. The head of safety now sat on the local safeguarding adults board and the prison had a good relationship with the local authority.

3.27 The most vulnerable prisoners were managed as inpatients on the health care unit. The prison had identified an additional 48 prisoners who were vulnerable or at risk, and they received a monthly welfare check from the safety team. Similarly, the safety team saw all 94 young prisoners under the age of 25 each month to check on their welfare needs.

3.28 Because staff training on safeguarding was limited, there was the risk that wing staff were not able to identify vulnerability or unmet needs effectively.

3.29 The prison had made reasonable progress against this recommendation.

Equality, diversity and faith

Concern: There were substantial weaknesses in equality work. The equality strategy was out of date and there was no multidisciplinary meeting to develop and drive action planning. There was limited consultation of prisoners in protected groups and little consideration of equality monitoring data.

Recommendation: Equality data and effective consultation should inform an effective strategy and action plan that leaders drive proactively to address disproportionate outcomes for prisoners from protected groups. (1.42)

3.30 There was a new equality and diversity strategy specific to Belmarsh that set out the establishment's approach and aims. The prison had also developed a new equality action plan with suitable priorities. The plan had been reviewed by HMPPS's national equality team and the Zahid Mubarek Trust (see Glossary). There had already been some good progress against many of the priorities in the plan, but actions that were ongoing did not have target dates for progress or completion.

3.31 A well-attended diversity and inclusion meeting had started in March 2022 and included prisoner representatives and the governor. The meeting included feedback from prisoners and examined a range of relevant issues. The minutes showed a marked improvement on previous equality meetings, with useful discussions and the development of suitable actions. It was too early to assess how effectively actions were followed up, but it was likely to be a useful vehicle for progress.

3.32 Analysis of equality data had improved and we saw evidence of several trends identified. Some work to investigate and address disproportionality had already begun (see paragraph 3.7). Data analysis was heavily focused on ethnicity, which was important but not sufficient given that other protected groups required analysis and discussion.

3.33 Consultation had resumed for most protected characteristic groups, with meetings generally taking place quarterly. This represented improved engagement with prisoners, who were able to feed back their views on a range of issues. However, some groups, such as foreign national prisoners, were not yet consulted, and the minutes indicated that consultation meetings were of variable quality; some demonstrated useful discussion and follow up, while others did not properly record how identified issues would be taken forward.

3.34 As well as reviewing the prison's strategic action plan, the Zahid Mubarek Trust had provided training to prisoners and staff on the discrimination incident reporting form (DIRF) process.

3.35 The prison had made reasonable progress against this recommendation.

Time out of cell

Concern: Prisoners who were not working spent up to 23 hours a day locked in their cells. Only 23% of prisoners were engaged in out-of-cell purposeful activity. Most prisoners had around 45-50 minutes outdoor exercise each day, although some got as little as 30 minutes. Association had not been available in the main prison since the restricted regime commenced in March 2020. The library remained closed and there were no developed plans to reopen it. Unlike in other prisons, the gym was still closed.

Recommendation: The core day should provide adequate time out of cell for purposeful activity, domestic tasks and recreation to assist with the rehabilitation of prisoners and to improve their well-being. (1.43)

3.36 Although time out of cell at Belmarsh was still inadequate, it had improved since the inspection and there were plans to in increase it further. Most prisoners received 45-60 minutes outdoor exercise each day, as well as up to 1.5 hours of association time. However, association time was regularly curtailed to an hour, mainly due to a shortage of staff, causing frustration for prisoners who had been told that they would receive the increased association period.

3.37 We were told that the majority of prisoners were now engaged in some out-of-cell purposeful activity, most of it part time. However, the prison's data were too poor to show how many prisoners were engaged in activities on any given day, or how frequently individual prisoners were in activity.

3.38 The gym and library had both reopened for in-person activities. Corporate worship had resumed, as had social visits, which were now available as often as before the pandemic. However, as gym and social visits took place during association time, prisoners sometimes had to choose between these activities and on-wing association.

3.39 One reason for the continuing limitations on activity time was that prisoners from different house blocks were not mixing during activities to minimise violence and conflict. Leaders planned to reintegrate activities, which would increase the time it was possible to unlock prisoners from each house block. They also intended to introduce more on-wing activities, although there was no timetable for this.

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

Education, skills and work

This part of the report is written by Ofsted inspectors. Ofsted's thematic approach reflects the monitoring visit methodology used for further education and skills providers. The themes set out the main areas for improvement in the prison's previous inspection report or progress monitoring visit letter.

Theme 1: What progress had leaders and managers made to rapidly increase the amount of classroom-based teaching available to prisoners and increase the number of prisoners from all areas of the prison who participate in education, skills and work?

3.41 Since our previous visit, leaders and managers had ensured that the number of prisoners benefitting from classroom-based teaching had risen. Leaders and managers had increased the capacity in each classroom and arranged for houseblocks to mix so that more prisoners could attend each session. Despite there being few classroom places available, managers did not ensure that all places were fully utilised. Too often prisoners were late to sessions because they were unlocked late.

3.42 In the past eight months managers had prioritised the re-introduction of education, skills and work activities appropriately to meet prisoners' educational needs. They focused on delivering qualifications in English and mathematics that matched the outcomes of prisoners' initial assessments and suited the high proportion of the prison population with low skills levels.

3.43 Managers had re-introduced some accredited vocational qualifications, such as peer mentoring and food safety. Managers had plans to introduce additional workshops in drylining and Construction Skills Certification Scheme (CSCS) cards, but these were not yet established. Recently, a small number of prisoners had benefitted from short courses, such as barista and first aid, and some prisoners had gained accredited qualifications.

3.44 Prisoners in the high security unit had little access to education and work opportunities. Most prisoners there were able to access English and mathematics lessons, but prisoners could not access work-related or vocational qualifications. Furthermore, these prisoners did not know what qualifications were available to them. Managers had plans in place to introduce horticulture and hard landscaping courses for prisoners in the high security unit, but these were not yet established. Vulnerable prisoners had few opportunities to access education and work or to gain accredited qualifications.

3.45 Managers had recently increased prisoners' opportunities to study through outreach and distance learning and more prisoners were taking these qualifications.

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

Theme 2: What progress had leaders and managers made to increase the number of prisoners who complete and return the education induction packs, including the initial assessment, so that staff can provide support and allocate prisoners to activities more effectively?

3.47 Since our previous visit, leaders and managers had taken practical steps to improve the induction process. Leaders had increased the number of prisoners who completed their education induction. Most prisoners completed their induction face-to-face rather than through the cell door. They completed their initial assessments in a timely way, within a few days of arriving at the prison. Managers monitored closely prisoners' attendance at education induction including the number of prisoners who were due to complete their assessments. Managers followed-up appropriately when prisoners did not attend.

3.48 During induction, tutors asked relevant questions to help prisoners to complete their initial assessments accurately. Tutors used the information from initial assessments effectively to identify appropriate courses for prisoners. The small number of prisoners who required additional learning support had clear support plans in place and tutors understood their learning needs well.

3.49 Tutors did not always ensure that prisoners' individual learning plans made clear how they would work towards their long-term career goals. For example, prisoners were allocated to the appropriate courses in English and mathematics to improve their skills. However, if they aspired to improve their catering or computer skills, there was not a clear plan to show how and when they could progress to those courses.

3.50 The information that prisoners received at the education induction, about the courses available to them, was very brief. It was not always clear how prisoners could access the relevant courses. Those prisoners who did not understand English well, found it difficult to complete the learning difficulty and disability questionnaire and to start their assessments. Tutors did not consistently ensure that the questions in the difficulty and disability forms were presented in a logical order. As a result, some prisoners found the induction process difficult to follow.

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

Theme 3: What progress had leaders and managers made to ensure that staff in education, skills and work are supporting and recording the development of prisoners' interpersonal skills?

3.52 Leaders had only recently introduced an updated 'progress in workshops' recording process for instructors to complete with prisoners. Leaders and managers had introduced the workbook successfully into a minority of workshops, such as textiles. A few prisoners engaged in discussions about their skills with instructors and they recognised the interpersonal skills they had gained, such as teamwork and working to deadlines. Instructors did not, however, ensure that all prisoners had access to the workbooks in a timely manner. As a result, the skills some prisoners gained at the start of their courses had not been recognised.

3.53 Leaders had been slow to ensure that instructors across all workshops used the new workbooks. They recognised that some instructors did not see the benefit of completing these or were not motivated to use them effectively in workshops.

3.54 In the vulnerable prisoners' packing workshop, instructors completed the workbooks appropriately. They used the information they had about prisoners' existing skills to set them personalised targets. As a result, tutors gave some prisoners additional responsibilities in the workshop which supported the development of their leadership and supervisory skills.

3.55 Too many prisoners did not benefit from gaining formal or informal accreditation of their skills. Tutors and managers did not provide sufficient opportunities for prisoners to take relevant qualifications in some workshops. Prisoners did not gain recognition of their progress, or a copy of their workbooks when they completed the course or when they left the prison. As a result, prisoners could not demonstrate the transferable skills they had gained to potential employers.

3.56 Ofsted found that the prison had made insufficient progress against this theme.

Public protection

Concern: There was no oversight of phone monitoring arrangements and staff assigned to this task told us that the increase in call volume following the introduction of in-cell telephones meant it was difficult to meet demand. Monitoring staff were not managed within the OMU [offender management unit] function and there was no clear ownership of this task. Leaders were surprised when we identified that calls by several prisoners had not been monitored for many weeks, and that some individuals had not been monitored at all.

Recommendation: All phone calls by prisoners covered by public protection monitoring should be listened to promptly to identify risk. (6.19)

3.57 There remained a significant backlog of telephone monitoring for public protection reasons and managers told us that it was a direct result of the increase in calls following the introduction of in-cell telephones. Managers were unable to produce records to show the size of the backlog. There was a lack of oversight of phone monitoring arrangements, no clear ownership of the task and no plans to address a concern that might have potentially serious implications.

3.58 There had been no meaningful progress against this recommendation.

Release planning

Concern: The decision to stop resettlement workers providing advice and support to unsentenced prisoners was a significant loss to these prisoners, who made up almost 60% of the population. While the decision was outside the control of the prison, it had not put in place any measures to mitigate this.

Recommendation: All prisoners, including those who are unsentenced, should be able to access resettlement advice and support to prepare them for their release into the community. (1.44)

3.59 Following national changes to the Probation Service in June 2021, the new contracts for resettlement support at all prisons did not include a provision for unsentenced prisoners. While the Probation Service had plans to address this in the future, at the time of the visit there was still no formal resettlement support for this group of prisoners.

3.60 Neither the information, advice and guidance staff nor the housing support provider were contracted to work with remand prisoners, although we saw examples of Jobcentre Plus staff providing advice to remand prisoners.

3.61 While resettlement workers saw all new arrivals, including those who had not yet been sentenced, the latter received no further support, even if they had a pressing concern, such as a risk of losing their tenancy. The consequences of this could be severe: the prisoner would be likely to be deemed intentionally homeless and the local authority would not have an obligation to house them on release. A lack of data on accommodation outcomes for remand prisoners meant it was not possible to quantify such cases, but resettlement staff were sure that this happened regularly.

3.62 The prison had not put in place any measures to mitigate such problems, such as upskilling resettlement staff to give advice on accommodation issues or providing information to remand prisoners about agencies in the community that could provide specialist support.

3.63 There was no systematic tracking of remand prisoners towards a likely sentencing date, and the resettlement team sometimes had insufficient time to address previously identified resettlement needs if a prisoner received a short sentence.

3.64 There had been no management meetings during the second half of 2021 to oversee and influence resettlement provision for any prisoners, although these had now resumed.

3.65 The prison had made no meaningful progress against this recommendation.

Section 4 Summary of judgements

A list of the HMI Prisons recommendations and Ofsted themes followed up at this visit and the judgements made.

HMI Prisons recommendations

Listeners should be able to carry out their role throughout the reception, first night and induction processes.
Good progress

Safety data should be used to inform a strategy and action plan to reduce increasing levels of violence, which leaders monitor and drive effectively.
Reasonable progress

There should be robust scrutiny of the use of force, including data, camera footage and staff statements, to make sure that force is necessary, justified and proportionate.
Reasonable progress

Prisoners at risk of suicide and self-harm should receive additional support through the use of good quality assessment, care in custody and teamwork (ACCT) case management that includes an accurate assessment of their risk, sufficiently frequent case reviews, appropriate support actions recorded in a care plan and a consistent record of their daily interactions.
Reasonable progress

Constant supervision arrangements should keep prisoners at risk safe and encourage them to engage with a purposeful regime wherever possible.
Reasonable progress

Prisoners defined as adults at risk of harm, abuse and neglect should be systematically identified and protected.
Reasonable progress

Equality data and effective consultation should inform an effective strategy and action plan that leaders drive proactively to address disproportionate outcomes for prisoners from protected groups.
Reasonable progress

The core day should provide adequate time out of cell for purposeful activity, domestic tasks and recreation to assist with the rehabilitation of prisoners and to improve their well-being.
Reasonable progress

All phone calls by prisoners covered by public protection monitoring should be listened to promptly to identify risk.
No meaningful progress

All prisoners, including those who are unsentenced, should be able to access resettlement advice and support to prepare them for their release into the community.
No meaningful progress

Ofsted themes

Rapidly increase the amount of classroom-based teaching available to prisoners.
Reasonable progress

Increase the number of prisoners who complete and return the education induction packs, including the initial assessment, so that staff can provide support and allocate prisoners to activities more effectively.
Reasonable progress

Ensure that staff in education, skills and work are supporting and recording the development of prisoners' interpersonal skills.
Insufficient progress

Appendix I About this report

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

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

Independent reviews of progress (IRPs) are designed to improve accountability to ministers about the progress prisons make towards achieving HM Inspectorate of Prisons' recommendations in between inspections. IRPs take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny and focus on a limited number of the recommendations made at the inspection. IRPs do not therefore result in assessments against our healthy prison tests. HM Inspectorate of Prisons' healthy prison tests are safety, respect, purposeful activity and rehabilitation and release planning. For more information see our website: https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/

The aims of IRPs are to:

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

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each recommendation we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in August 2021 for further detail on the original findings (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/).

IRP methodology

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

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

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

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

Insufficient progress
Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken since our inspection had had not yet resulted in sufficient evidence of progress (for example, better and embedded systems and processes).

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

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

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

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

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

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

Ofsted’s approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook*, available at https://www.gov.uk/government/publications/education-inspection-framework.

Inspection team

This independent review of progress was carried out by:

Hindpal Singh Bhui	Team leader
Rebecca Mavin	Inspector
David Owens	Inspector
Tamara Pattinson	Inspector
Lynda Brown	Ofsted inspector
Jane Hughes	Ofsted inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. 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/

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.

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

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).

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.

Zahid Mubarek Trust
An independent national charity seeking to ensure fair and humane treatment and conditions in prisons.

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

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