Report on an independent review of progress at

HMP/YOI Chelmsford

by HM Chief Inspector of Prisons

15–17 August 2022

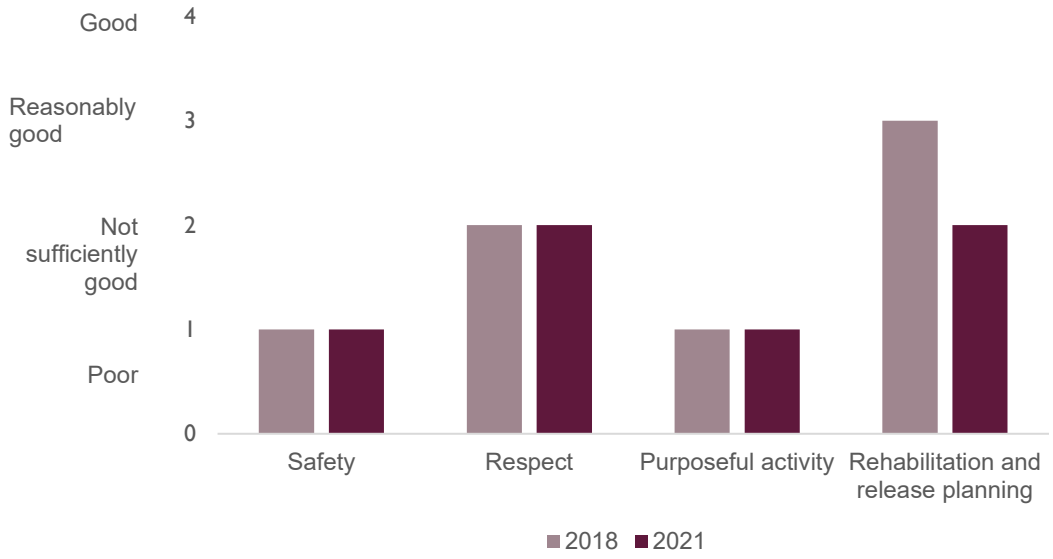
Contents

Section 1 Chief Inspector's summary

1.1 HMP Chelmsford is a category B local and resettlement prison for adult and young adult men. It has a mix of older wings dating back to the Victorian era and more modern accommodation added from the late 1990s. At the time of this visit, the prison held around 650 prisoners, most of whom were remanded by the courts or awaiting sentencing. The population had been temporarily reduced by 50 to enable much needed refurbishment of some of the accommodation, but the prison remained unacceptably overcrowded, with about half the prisoners sharing cells designed for one.

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

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



1.3 At our last unannounced inspection in August 2021, we identified numerous failings in the treatment and conditions of prisoners that were so concerning I decided to invoke the Urgent Notification Protocol and wrote to the Secretary of State.

1.4 The last time we had been able to write a positive report about the prison had been more than a decade ago and it was clear that the jail was failing in its basic duty to keep those it held safe. We found a negative and damaging staff culture and prisoners found it very difficult to access even the most basic entitlements. 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 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.

1.5 I concluded my letter to the Secretary of State by saying that HMP/YOI 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 would require strong and consistent leadership at all levels in the prison and much more effective support from HMPPS than the approach it had taken in recent years, which had failed completely to arrest the drift and decline at the prison.

1.6 During this review visit, our findings were encouraging. There was evidence that the governor, who had taken up post a few months before our last inspection, was giving the strength of leadership and direction that was needed to turn the prison around. There had been good or reasonable progress against five of the eight recommendations that we examined, although there remained insufficient progress against three. Ofsted found only reasonable progress in one theme and two remained insufficient. We also found insufficient progress in relation to purposeful activity. The time that prisoners spent unlocked remained poor and unpredictable, largely due to staff shortages. Those who were unemployed still spent more than 22 hours locked up each day.

1.7 There had been considerable effort, however, by the senior team to address the serious concerns identified at the last inspection and we found good progress in key areas. Living conditions were cleaner and more decent and cells had been refurbished by prisoners and were better equipped. Overall, improvements in processes, including for applications and telephone PIN numbers, had reduced prisoners' frustration, and we found more helpful and supportive interactions between staff and prisoners. The progress in reducing the availability of illicit drugs, which had underpinned many of the troubling outcomes in safety at the prison for far too long, was particularly impressive.

1.8 The reasonable progress we found in the work to reduce violence and prevent suicide and self-harm also reflected a prison that had renewed its sense of purpose and had clearer direction. There were now a range of initiatives to make the prison safer and care for individuals was more thoughtful and supportive. Analysis of data had much improved and underpinned a better understanding of the reasons for violence and self-harm. Early indications of improvement in outcomes were promising.

1.9 Although health care services had improved in some important areas, with better partnership working and levels of staffing, progress overall remained insufficient. Too many appointments had to be cancelled because of a shortage of officers to escort prisoners to health care, and the limited access to the dental service was compounded by its own staff shortage. We also found insufficient progress in addressing our

concern about gaps in measures for public protection. Although Ofsted considered that there had been reasonable progress in providing support for those with a learning difficulty or disability, progress in increasing the number of activity places and in providing advice and guidance to direct prisoners to the most appropriate learning and work remained inadequate.

1.10 Overall, this was a positive and promising review. The governor, his senior team and staff should be congratulated on what they have achieved so far in addressing the shortcomings identified in the Urgent Notification. Greater ambition is now required to increase the time that prisoners spend out of their cell and in work or education. Consistent leadership, continuing HMPPS support and sufficient staff will also be needed to sustain this creditable progress.

Charlie Taylor
HM Chief Inspector of Prisons
August 2022

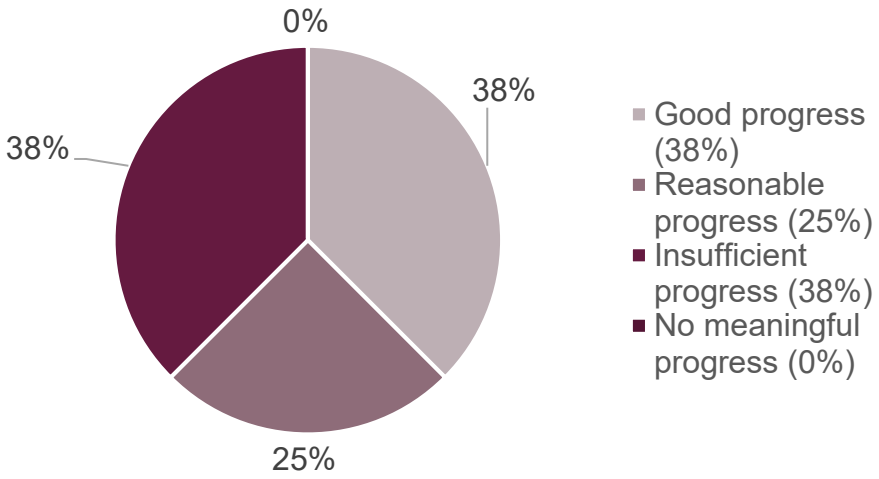
Section 2 Key findings

2.1 At this IRP visit, we followed up eight 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 three recommendations, reasonable progress in two recommendations and insufficient progress in three recommendations.

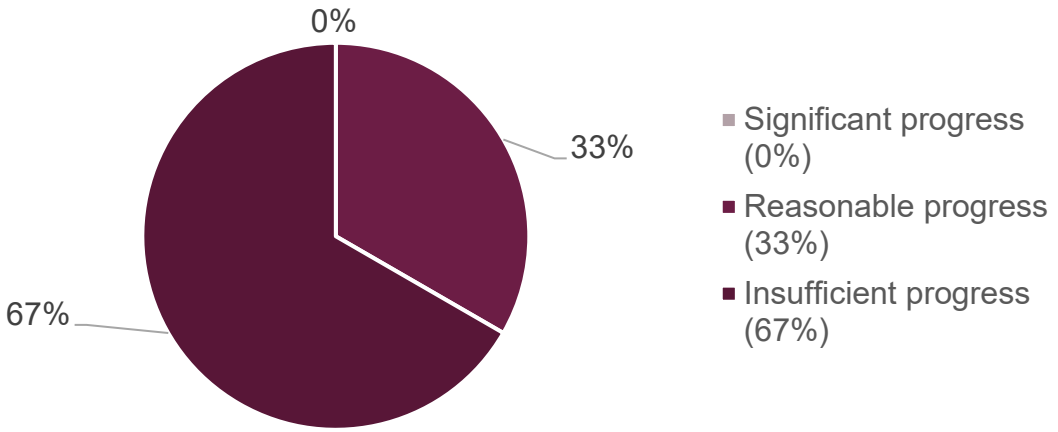
Figure 2: Progress on HMI Prisons recommendations from 2021 inspection (n=8)

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 one theme and insufficient progress in two themes.

Figure 3: Progress on Ofsted themes from 2021 inspection/progress monitoring visit (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 comprehensive strategy to reduce ingress of illicit drugs, including strengthening physical security, better links with the local community, collaboration with the police and increased use of available technology, had been successful. Staff and prisoners both told us how scarce illicit drugs now were in the prison. (See paragraph 3.8.)

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.

Managing behaviour

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. (1.33)

3.1 Levels of violence had reduced by about 17% during the previous 12 months when compared with the 12 months before our inspection, although the rate remained above the average for this type of prison. Violent incidents for the year to date showed a gradual increase, but few assaults were recorded as serious.

3.2 A local survey indicated that prisoners now felt much safer and those we spoke to during our visit supported this view.

3.3 Analysis of data had much improved and underpinned a much better understanding of the reasons for violence.

3.4 A range of initiatives that included conflict resolution training for both staff and prisoners and an event focusing on young adults had been implemented to support violence reduction. Prisoners had also been consulted through a 'safety summit' when prisoners were involved in activities to develop a strategy for managing confrontation safely.

3.5 The safety team had been strengthened following the recruitment of an analyst and the recent 'ring-fencing' of dedicated safer custody officers to limit their redeployment.

3.6 Perpetrators of violence were managed well under challenge, support and intervention plans (CSIPs, see Glossary). Residential managers now took the lead which supported a prison-wide approach to managing poor behaviour. Case reviews were timely and well formulated.

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

Security

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. (1.34)

3.8 The ingress of drugs had been reduced. The main routes had been identified as trafficking through visits and reception, contraband being thrown over the wall and impregnated mail. Staff and prisoners both told us how scarce illicit drugs now were in the prison and we did not smell drugs or tobacco during our visit.

3.9 Physical security had been strengthened at known sites for 'throw-overs' with the replacement of windows, additional CCTV and more perimeter patrols. The governor had also developed stronger links with the local community to encourage the reporting of suspicious activity. Collaboration with the local police had increased the number of patrols in the area and their response times when needed.

3.10 The number of throw-overs of illicit drugs had greatly reduced. During the month of our previous inspection, August 2021, 60 had been recorded compared with just seven over the six months before this visit. Drug finds during cell searches were now also rare.

3.11 Measures to prevent mail impregnated with drugs were robust, including arrangements to detect bogus legal mail. Psychoactive substance (see Glossary) medical emergencies were much reduced, with just two recorded in the last 12 months.

3.12 The body scanner in reception was now routinely used to screen newly arrived prisoners and had identified about 15% of those scanned attempting to traffic contraband into the prison in recent months.

3.13 Intelligence indicated that prisoners still wishing to obtain drugs were now more focussed on tradeable prescribed medication and illicitly brewed alcohol (hooch). In response search dogs were routinely

deployed across the prison and in-possession medicine checks were now undertaken.

3.14 Drug testing had recently been reintroduced and indicated a failure rate of about 10% for random tests, mostly for diverted medication, which was considerably lower than the positive drug testing rate of 36.8% recorded when we last visited the prison (for an independent review of progress) in 2019. A considerable amount of other testing was being carried out.

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

Safeguarding

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 was 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 ACCT procedures (assessment, care in custody and teamwork case management of prisoners at risk of suicide and self-harm) 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. (1.35)

3.16 There had been no self-inflicted deaths since our last inspection, but self-harm remained high. The number of recorded self-harm incidents had increased by 80 (9%) during the previous 12 months compared to the last inspection. The rate of self-harm remained the second highest among comparator prisons.

3.17 Leaders had completed a full review of recommendations from Prisons and Probation Ombudsman investigations and repeated recommendations were regularly reviewed to ensure that processes were embedded. Investigations into serious incidents of self-harm to identify learning had also been completed. The serious safety flaws we identified during our night visit at the last inspection had been largely addressed. Staff told us that they were aware of their responsibilities during a medical emergency and would enter cells as quickly as possible in life-threatening situations. At our previous inspection, most

staff we spoke to had said that they would always wait before entering a cell in an emergency, which would delay the prisoner receiving the emergency help they needed.

3.18 Data analysis had improved following the appointment of an analyst. Leaders now had a good understanding of the drivers and causes of self-harm. Prisoners' frustration at being locked in their cell with no purposeful activity was given as the most common reason.

3.19 Individual prisoners in crisis had been well supported through improved joint working with the mental health team. Some newly arrived prisoners with a history of repeated self-harm had been invited to meet the safer custody team informally. Chelmsford was also a pilot site for 'unlock my life', a new initiative to train some staff and prisoners as mental health ambassadors.

3.20 Staff were much more confident in using the ACCT document (assessment, care in custody and teamwork case management of prisoners at risk of suicide and self-harm) and the number of open documents had reduced since the last inspection. The quality of reviews and care planning had improved overall, for example, families were now sometimes involved in the review process. Most prisoners we spoke to said they felt supported by staff while on an ACCT. Quality assurance took place regularly and learning was shared with managers. Thirteen officers identified as ACCT champions offered peer support and guidance on the ACCT process.

3.21 The number of Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) had increased, but prisoners told us that access was not always facilitated. There had been three Listener training courses during the previous 12 months and 18 Listeners were active at the time of our visit and supported by the Samaritans and the safer custody team.

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

Staff prisoner relationships

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 demonstrated 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 should 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. (1.36)

3.23 We observed positive and supportive interactions between staff and prisoners. Prisoners told us that most staff now treated them with respect, and most prisoners said they could identify somebody to turn to for help.

3.24 Improvements in living conditions and procedures, such as general applications, telephone pin numbers and complaints, had reduced prisoners' frustration. Prisoners told us that staff were more receptive and that their response to basic requests had improved. Monthly prison council meetings had been held which were well attended by prisoner wing representatives and staff from many areas of the prison. Meaningful discussions took place and tracking of actions was improving.

3.25 Accountability and managerial oversight had improved. We observed visible leadership on the wings with leaders engaging positively with staff and prisoners. Regular performance meetings were held with all managers and some negative staff behaviour had been appropriately challenged by leaders.

3.26 A staff culture review had been completed and actions to drive improvements further were being implemented. The HMPPS Prison Performance Support Programme was helping to consolidate and monitor key actions and a culture lead manager had been recruited. The HMPPS standards coaching team of experienced officers had visited Chelmsford for 12 weeks and we were told that staff confidence and competence in their daily tasks had improved. More staff had asked for coaching support and this had been facilitated.

3.27 Additional support had been provided to new staff through mentoring and a buddy scheme. Some officers had been trained as trauma risk management practitioners and mental health allies which supported staff well-being.

3.28 Attempts had been made to increase the number of key worker sessions by using staff who were on restricted duties but overall the sessions remained very limited.

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

Living conditions

Concern: Many cells were cramped, in poor repair and grubby and those on the first night unit remained poorly prepared. Many cells were marked with graffiti 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. (1.37)

3.30 Good work had taken place to make sure that prisoners lived in a cleaner and more decent environment. A programme of continuous improvement was well under way to address the concerns raised at our last inspection.

3.31 Sixty per cent of cells had been repainted and graffiti removed. Damp cells had been put out of use to await repair. Refurbishment of communal showers had started, some cell window grilles had been replaced and new servery equipment installed.

Servery

3.32 Staff now carried out weekly decency and kit checks to make sure that progress was maintained. Living areas were cleaner, in better repair and with improved equipment, although not all cells had curtains.

Prisoner work parties had been recruited to undertake minor maintenance tasks, such as fixing toilet seats and lids.

C wing showers during the 2021 inspection (top) and during this review of progress

3.33 First night cells on the induction unit were now better prepared and the upper landing had new flooring.

3.34 Outside areas, including cell window grilles, were now clear of rubbish and regular pest control and the capping of drains had been successful in eradicating the infestation of vermin.

Rubbish in the window grilles during the 2021 inspection (top) and during this review of progress

3.35 The prison remained overcrowded and nearly half the population (49%) were sharing cells designed for one person. The population had been temporarily reduced by 50 to facilitate refurbishment of some of the accommodation.

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

Health, well-being and social care

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 were 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. (1.38)

3.37 Partnership work between senior prison and health care leaders had improved. There was also more health care representation at a range of prison meetings.

3.38 Too many health care appointments had to be cancelled because of a shortage of officers to escort patients. This also affected external hospital appointments, with around 20% having been cancelled in the first six months of the year, and we found evidence of unmet need.

3.39 There were several staff vacancies in the primary care team, although staffing in mental health and the pharmacy had improved. Vacant posts were covered by a consistent group of agency staff.

3.40 Medicines management systems had been strengthened and most patients received their medication in a timely manner. When medication could not be administered, the reason was not consistently recorded. The supervision of queues by officers for the dispensing of medication remained inconsistent.

3.41 On the enhanced care unit, we found a failure to provide adequate oversight or coordination of the care for patients with complex care needs, some of whom lacked mental capacity. Patients who refused medication were not followed up and decisions had not been made in their best interest despite an assessment of their capacity. Care was not co-ordinated well enough between primary care and mental health to make sure that risks were appropriately managed and patient needs met, which was poor. We raised this with the head of health care and a multidisciplinary meeting was set up to discuss the patients' best interests.

3.42 Limited access to dental services was compounded by a shortage of dental staff and clinics only ran on two out of three days, which was

poor. There was an unacceptably long waiting list and patients across the prison told inspectors of the difficulty in obtaining an appointment to address outstanding dental issues or urgent treatment needs.

3.43 The complaints process was advertised on the wings, which was an improvement. The responses to complaints lacked empathy and were often late and poorly written, which was unacceptable.

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

Time out of cell

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 their cell for 22 hours a day. Plans to introduce a meaningful regime were limited and were 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. (1.39)

3.45 Although regime timings had now been published, predictable time out of cell was still not consistently delivered because of staff shortages. Prisoners repeatedly told us that their access to 30 minutes' exercise and 45 minutes for domestic activities could be curtailed at short notice, and time out of cell varied depending on which staff were on duty.

3.46 More than 40% of the population were unemployed. They were locked in their cell for at least 22 hours a day which continued to place an inevitable toll on their well-being. Some newly arrived prisoners on the induction wing had as little as an hour a day out of their cell. Most prisoners spent only 2.5 hours unlocked on Saturday and Sunday.

3.47 More prisoners had been allocated to work and education than at the time of our last inspection: twenty-nine per cent of prisoners were allocated to full-time work and could spend up to seven hours a day out of their cell. A further 30% were employed part time and could expect 4.5 hours unlocked. Prisoners living on the enhanced unit could have about six hours a day out of cell, which was positive.

3.48 However, at our roll checks 42% of prisoners were locked up during the working day and only 16% were off the wing at work or education. A further 9% were working on the wing. This was a slight improvement since our last inspection when 50% of prisoners were locked up during the day.

3.49 Outdoor exercise periods were still too short at 30 minutes a day and not all full-time workers received this.

3.50 Many prisoners had access to the gym twice a week and participation rates were high. However, the well-resourced library was not widely accessible because there was a shortage of officers to escort prisoners there.

3.51 We considered that the prison had made insufficient 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: The number of available places in education, skills and work should be increased. Leaders should also improve attendance and punctuality. (5.16)

3.52 Leaders and managers had not been able to provide sufficient places for prisoners to be able to participate in education, skills and work. There had been some improvement since our last visit a year ago, but too many prisoners were still not engaged in developing the knowledge and skills they needed to get jobs on release. Furthermore, leaders and managers had not ensured that all the available activity places were used. Many jobs on the wings and in industries were vacant.

3.53 Staff shortages had resulted in many prisoners awaiting induction and not able to start education or work. It took too long for many prisoners to start education or work after arriving at the prison.

3.54 Leaders and managers had not provided enough staff for prisoners to attend education, skills and work for sufficient hours a week. Full-time education or work for the great majority of prisoners was curtailed, with shorter working days and a four-day working week. Consequently, prisoners did not experience the rigours of a normal working week as experienced in wider society. This also prevented prisoners from developing their knowledge and skills to a full extent and better preparing them for roles in wider society.

3.55 Leaders and managers had made sure that attendance in most industries and work settings was satisfactory, but too much learning time was lost through lateness. In education and training, attendance was still too low, although lessons did start on time.

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

Theme 2: 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. (5.17)

3.57 Information, advice and guidance (IAG) staff were not sufficiently qualified or experienced. Staff were undertaking appropriate qualifications but had yet to enhance their knowledge and skills enough to provide a fully effective service to prisoners.

3.58 IAG advisers did not focus personal learning plans on what prisoners needed to do to achieve their career goals. These plans did not contain useful short-term targets which could be realistically achieved in the prison, nor did they contain practical guidance on options available in the prison or to help prepare for release. Too many prisoners were not allocated to education, skills and work in accordance with their personal learning plan.

3.59 Many prisoners had not received IAG. Too often, the results of mathematics and English assessments were not available to inform the development of personal learning plans. As a result, too many prisoners were unclear about the steps to take to achieve their goals in these subjects.

3.60 Staff shortages prevented vulnerable prisoners from accessing the broad range of education or work options open to other prisoners. For example, they did not have access to personal development programmes or English for speakers of other languages (ESOL).

3.61 Not enough staff were available to give prisoners the necessary support to prepare for work on release. Workshops to support job applications or interview skills were not available. Following security issues, prisoners were unable to use the virtual campus (prisoner access to community education, training and employment opportunities via the internet) to support the development of their employability skills. Leaders had not made sure that there were enough links with employers to enable prisoners to have a sufficiently broad understanding of employment options.

3.62 Since our previous visit, managers had appropriately prioritised and sequenced the development of English and mathematics skills in the allocation process. As a result, prisoners could not attend work or industries unless they had achieved the required level for that role.

3.63 Ofsted considered that the prison had made insufficient progress against this theme.

Theme 3: 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. (5.18)

3.64 Since our previous visit, leaders and managers had ensured that all staff across the prison had received extensive awareness training in how to support prisoners with learning difficulties and disabilities (LDDs). As a result, staff had a much greater understanding of prisoners' learning needs and how this affected their daily lives.

3.65 Leaders and managers had appointed a well-qualified learner support team of three inclusion support coordinators (ISCs) and an experienced manager. ISCs had received specific training in teaching and learning approaches to help prisoners overcome their learning difficulties. As a result, they knew how to support prisoners with complex needs through effective teaching strategies, for example making sentences understandable by breaking text down into its component parts.

3.66 Leaders and managers had greatly improved the assessments of prisoners' individual support needs. Prisoners with an identified need undertook a comprehensive assessment with specialist staff. More than a third of prisoners in education and training had received this full assessment and benefited from intensive support.

3.67 Teachers received very valuable support from the ISCs. They used the analysis of prisoners' individual needs and helpful guidance on different teaching and learning strategies. They also planned their lessons to make learning more accessible and productive. As a result, pass rates for prisoners with LDDs were broadly equal to other groups.

3.68 However, leaders had yet to achieve the high levels of support for prisoners with LDDs in work and industries. Leaders recognised the need to provide parity across all areas of education, work and skills and had designed a learning support programme for prisoners in work and industries. The benefits of this recent development had yet to be realised.

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

Public protection

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. (1.40)

3.70 A monthly interdepartmental risk management team meeting had been introduced swiftly following our last inspection.

3.71 While the scope of the meeting was still being developed, it provided an improved oversight of risk planning arrangements for prisoners who were subject to multi-agency public protection arrangements (MAPPA). These prisoners were considered at frequent intervals and in good time before their release to ensure an appropriate handover of responsibility and sharing of information with community offender managers. Thirteen prisoners were due for release during the three months after our visit and all but one had their MAPPA level confirmed.

3.72 There were gaps in collaborative oversight of other high-risk prisoners, such as those not subject to MAPPA and short-term recalls. Work had recently started to address some of these deficits with the introduction of an additional monthly risk screening meeting.

3.73 During the week before our visit, offender management unit managers had started to develop and implement a more robust approach to improve public protection monitoring arrangements. This included transferring paper files to electronic files and ensuring that records were centralised and accessible to those who needed them.

3.74 However, there were still too many gaps. Weaknesses in administrative processes meant that reviews of prisoners to determine whether they should remain on monitoring were not always timely nor were decisions shared promptly. There were also gaps and delays in calls being listened to and monitoring logs were not detailed enough or up to date.

3.75 We considered that the prison had made insufficient 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

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.
Reasonable progress

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.
Good progress

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.
Reasonable progress

Prisoners' perceptions of their treatment should be improved. Staff should 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.
Good progress

Prisoners should live in a clean and decent environment that is in a good state of repair and fit for purpose.
Good progress

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.
Insufficient progress

Prisoners should have regular and predictable time out of cell, which is sufficient to promote rehabilitation and mental well-being.
Insufficient progress

Public protection measures and oversight to manage those presenting a risk of serious harm should be applied robustly.
Insufficient progress

Ofsted themes

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

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.
Insufficient progress

Theme 3: 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.
Reasonable 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 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:

Sara Pennington	Team leader
Jade Richards	Inspector
Natalie Heeks	Inspector
Paul Rowlands	Inspector
Sarah Goodwin	Health and social care inspector
Bev Gray	Care Quality Commission inspector
Allan Shaw	Ofsted inspector
Shane Langthorne	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/

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.

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).

Psychoactive substances
Psychoactive substances are either naturally occurring, semi-synthetic or fully synthetic compounds. When taken they affect thought processes or individuals' emotional state. In prisons, these substances are commonly referred to as 'spice'. For more information see https://www.gov.uk/guidance/psychoactive-substances-in-prisons#what-are-psychoactive-substances

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.

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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