Report on an unannounced inspection of

HMP Maidstone

by HM Chief Inspector of Prisons

3–14 October 2022

Contents

Introduction.. 3

What needs to improve at HMP Maidstone 5

About HMP Maidstone 7

Section 1 Summary of key findings.. 9

Section 2 Leadership 15

Section 3 Safety 17

Section 4 Respect.. 24

Section 5 Purposeful activity 41

Section 6 Rehabilitation and release planning 47

Section 7 Summary of priority and key concerns... 54

Section 8 Progress on recommendations from the last full inspection report 56

Appendix I About our inspections and reports 64

Appendix II Glossary 67

Appendix III Care Quality Commission Requirement Notice......... 69

Appendix IV Further resources 72

Introduction

Maidstone is a category C training prison that held 579 foreign national offenders at the time of our inspection, many of whom were likely to be deported at the end of their sentences.

The prison is more than 200 years old and some of the original, dark, cavernous, and sometimes damp cells remained, with poor ventilation and little natural light. These spartan conditions were, in part, mitigated by very high standards of cleanliness and the fact that most prisoners were in single cells. There was also a programme to improve the showers which meant they were mostly better than we saw in our last visit.

The governor, well-liked by both prisoners and staff, had arrived just six months before the inspection and had begun to make improvements, setting clear, suitable and well-communicated priorities.

This included an improvement in the regime, which meant that since September, prisoners in work or education were out of their cells for seven hours and 45 minutes a day, while those who were unemployed had four hours. This was much better than we had seen in most of our recent category C inspections. The provision of suitable work or education was rated inadequate by Ofsted and the provider had failed to provide a curriculum that fitted with labour shortages in the community or took into account the restrictions on working for prisoners whose immigration status was in doubt. This situation had not improved since our last inspection in 2018 and reflected the poor service that was being provided by the education contractor. For example, there was no English teacher – a huge loss given the nature of the population – and there was no strategy in place to teach prisoners to read.

In our survey, the number of prisoners who told us that staff treated them with respect had reduced compared with our last inspection and this finding was backed up by our observations on the wings and in many discussions with prisoners. There were some excellent officers who engaged with the men very well and the atmosphere in the prison was mostly good, but some staff did not appear to understand the needs of this group of prisoners, particularly the many who were held over tariff or who were contesting their immigration status. We were told of cases where prisoners had reported to officers that they were feeling depressed and were told to fill out an application form to mental health services.

The anxiety of prisoners in Maidstone was increased by Home Office delays in processing their cases. Mechanisms for releasing prisoners who had been assessed as having the highest level of evidenced risk under the Adults at Risk policy were not fully functioning, meaning that some over-tariff prisoners were being held despite assessments revealing that continued incarceration was damaging their mental health. The complaints and applications system was in disarray, adding to the frustrations of prisoners Thirty-six per cent of prisoners from Maidstone were released back into the community, yet the level of support that they receive was very limited because prison offender managers could not

begin planning this process until the Home Office had made a decision about their continued status.

Our most concerning finding was that there was limited use of the translation service by staff. This meant that some potentially vulnerable prisoners, who may have been at risk of suicide or self-harm, were not adequately assessed or triaged, particularly when they first came into the prison. Key documents from the Home Office relating to prisoners' cases were only printed in English and some men told us they had been asked to sign documents that they did not understand.

Although this report contains some disappointing findings, with a new and effective governor in place I was left with the sense that Maidstone is a prison that will continue to improve. I hope this report will be used as a springboard to drive forward progress.

Charlie Taylor
HM Chief Inspector of Prisons
November 2022

What needs to improve at HMP Maidstone

During this inspection we identified 15 key concerns, of which five should be treated as priorities. Priority concerns are those that are most important to improving outcomes for prisoners. They require immediate attention by leaders and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

1. **Staff did not have enough understanding of or react effectively to the particular needs of the population of this jail in which prisoners were often vulnerable, anxious and distressed.**

2. **Professional interpretation services were not used enough.** The experience of those who spoke little or no English was poor.

3. **The systems for dealing with prisoners' applications and complaints were ineffective** and were the cause of much frustration.

4. **External hospital appointments and orders for medical equipment were not managed well.** Staff had not followed up some important referrals and orders for equipment, with negative effects on the health and well-being of some patients.

5. **There were not enough staff in education, skills and work to plan and teach a curriculum that fully met the needs of the population and to bring about the necessary improvements in quality and performance.** Leaders had not reviewed their curriculum offer to make sure that it was of high quality and relevant to the needs of the population.

Key concerns

6. **The oversight and scrutiny of the use of force were weak.** Poor practice was often not identified and learning from incidents was not passed on to staff so that they could improve their performance.

7. **Too many staff were passive or distant in their interactions with prisoners.** Key work sessions were not frequent enough, nor always properly focused or helpful in dealing with the individual's issues.

8. **Although there had been some improvements to living conditions, some parts of the estate were barely fit for purpose.** Some cells were too small, damp and cold with damaged windows, no toilet screening and damaged furniture. Many showers were in a poor state.

9. **The food was unpopular with prisoners and had deteriorated since the last inspection.** Some poor practice in the serving of meals prejudiced food safety.

10. **The delivery of some areas of the pharmacy service was not effective.** In the absence of adequate professional oversight, there were some deficiencies in the recording and control of the use of medicines.

11. **Leaders and managers had not improved the quality of the education, skills and work provision to bring the teaching that prisoners received to a good standard.** The quality of education and vocational lessons was too variable. Some teachers did not check learning effectively and did not support prisoners to improve their knowledge and skills.

12. **Leaders did not ensure that prisoners accessed education, skills and work activities appropriate to their identified needs, in a timely and sequenced way.** Staff did not allocate prisoners to the activities identified as most appropriate for them. Leaders did not maximise activity spaces and more than a fifth of prisoners were unemployed.

13. **There were no programmes to address offending behaviour.** Many prisoners needing such a course could not move to a prison which delivered it. As a result, they were unable to progress with their sentence.

14. **Prisoners' resettlement needs were not always met, especially in key areas such as housing and benefits, despite good systems to identify them.**

Care Quality Commission regulatory recommendation

Providers should have suitable systems and processes in place and should make sure that they are operated effectively.

About HMP Maidstone

Task of the prison/establishment
Category C prison holding male foreign national prisoners.

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 579
Baseline certified normal capacity: 565
In-use certified normal capacity: 560
Operational capacity: 600

Population of the prison
- 69 new prisoners received on average each month.
- 50% of prisoners from black and minority ethnic backgrounds.
- About 40% aged under 30.
- 36% of prisoners released into the community.
- 79 prisoners receiving support for substance misuse.

Prison status (public or private) and key providers
Public

Physical health provider: Oxleas NHS Foundation Trust
Mental health provider: Oxleas NHS Foundation Trust
Substance misuse treatment provider: Change Grow Live (CGL)
Prison education framework provider: Weston College
Escort contractor: Serco, Mitie Care and Custody

Prison group/Department
Kent, Surrey and Sussex

Brief history
Maidstone prison was built in 1819. The prison was re-roled in 2013 and is now a designated foreign national prison.

Short description of residential units
There are four residential units and one segregation unit.

Kent unit - built in 1850, holds up to 176 prisoners in single cells.
Medway unit - built in 1966, holds 101 prisoners in single cells.
Thanet unit - built in 1909 and extended in the 1970s, holds 174 prisoners in single cells.
Weald unit – refurbished in 2009, holds 149 prisoners in single and double cells
Segregation unit can hold nine prisoners.

Name of governor and date in post
Dawn Mauldon, April 2022 –

Changes of governor since the last inspection
Judith Feline, April 2019
Dave Atkinson, May 2013

Prison Group Director
James Lucas

Independent Monitoring Board chair
Peter Bateman

Date of last inspection
October 2018

Section 1 Summary of key findings

1.1 We last inspected HMP Maidstone in 2018 and made 72 recommendations, six of which were about areas of key concern. The prison fully accepted 60 of the recommendations and partially (or subject to resources) accepted nine. It rejected three of the recommendations.

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

Progress on key concerns and recommendations from the full inspection

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

1.4 At our last full inspection, we made six recommendations about key concerns. At this inspection we found that none of those recommendations had been achieved, two had been partially achieved and four had not been achieved. At this inspection we found that the one recommendation in safety had been partially achieved. Similarly, the one recommendation in respect was partially achieved. All three recommendations in purposeful activity as well as the one recommendation in rehabilitation and release planning were not achieved. For a full summary of the recommendations achieved, partially achieved and not achieved, please see Section 8.

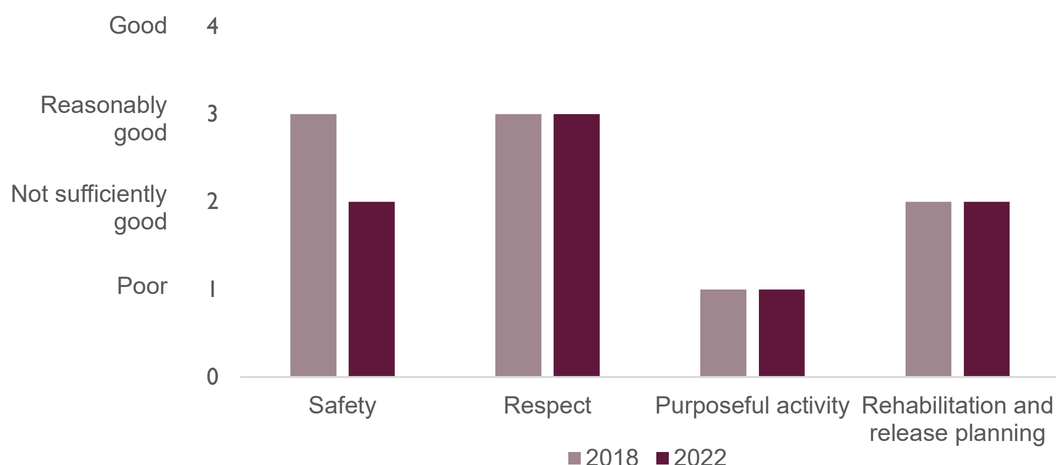
Outcomes for prisoners

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

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

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

Figure 1: HMP Maidstone healthy prison outcomes 2018 and 2022



Safety

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

At this inspection we found that outcomes for prisoners were now insufficiently good.

1.8 The reception area had not improved and some interviews were conducted with no privacy. Reception staff were polite but the lack of interpretation for non-English speakers was pervasive and undermined safety. Induction was led enthusiastically by peer workers.

1.9 The overall rate of violence had reduced since the last inspection, although there had been a homicide within the last year. Recording and investigation of violent incidents were reasonably good, but data were not always well used to understand and respond to emerging safety issues.

1.10 In our survey, more prisoners than at the previous inspection said they felt unsafe. Many attributed this to their uncertain immigration status, but others raised concerns about debt and antisocial behaviour. Challenge, support and intervention plans were widely used in response to violence but were underused for victims and for those exhibiting concerning behaviours.

1.11 The incentives scheme worked reasonably well, although there were few incentives to promote positive behaviour. There were considerably fewer adjudications than at the last inspection and better investigation of charges.

1.12 The oversight of use of force was weak. Most staff now carried body-worn cameras, but they often switched them on too late. Use of segregation had reduced since the previous inspection and segregated prisoners were treated fairly.

1.13 Physical security was generally proportionate, with free movement to and from work. There was still some over-use of strip-searching and handcuffing. There was a good flow of intelligence, but data were not used well enough to identify actions. Work had been done to reduce the ingress of illicit items, but drug use remained a challenge.

1.14 There had been one self-inflicted death since the last inspection. Self-harm rates were low, although we observed widespread anxiety and distress. Some staff were alert to this, while others were less forthcoming in offering informal support. The quality of support for those at risk of self-harm was not high.

Respect

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

At this inspection we found that outcomes for prisoners remained reasonably good.

1.15 We saw some very good interactions, but others were passive and distant. Low-level poor behaviour generally went unchallenged.

1.16 There were some examples of good key work and many prisoners had a key worker, but conversations were often superficial. The experience of those speaking little or no English was worse. Peer supporters were well used, although some needed better training and supervision.

1.17 There was little overcrowding and most prisoners were in single cells. Some improvements had been made to the accommodation, but parts of the ageing jail remained barely fit for purpose. There was very little graffiti and outside areas were well maintained.

1.18 Access to clean clothing, bedding and showers was good. Most shower rooms were in poor condition although refurbishment had started. The response to cell call bells was often too slow, but leaders had started to address this.

1.19 The quality of the food had dipped since the last inspection. Prisoners were concerned about refunds for missing items and poor administration of catalogue orders.

1.20 The prison council was well established and effective. Leaders had recognised that applications and complaints were poorly handled, causing widespread frustration, and were trying to address this.

1.21 A revitalised diversity and inclusion action plan was starting to inform progress. Collection and analysis of data were good but had not yet been used to plan or implement change. Consultation with protected characteristic groups had resumed intermittently. Investigation of alleged discrimination had improved.

1.22 The chaplaincy played a full part in the life of the prison. Almost all prisoners had access to a chaplain of their own faith, while the chaplaincy was providing excellent access to communal worship and good pastoral support.

1.23 Many aspects of health care services were reasonably good and the experienced managers were supported by conscientious staff. The management of long-term conditions had improved. There had been some problems with referrals, including those for social care, and hospital appointments. Some responses to complaints were unsatisfactory. Not enough use was made of telephone interpreting services.

1.24 The mental health in-reach team delivered a responsive service and knew their patients well. Access to psychological therapies was improving.

1.25 Clinical substance misuse support was good. Psychosocial individual support was also good and groups had recently restarted. There were some weaknesses in the management of medicines. Waits for routine dental care had reduced to less than six weeks.

Purposeful activity

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

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

1.26 Time out of cell had increased in recent weeks, but unlock times were inconsistent. More than half the prisoners remained on the wing during the working day. Prisoners were not out of their cells enough at weekends because there were too few staff.

1.27 Library access was limited but books could be ordered. The librarian was using data to plan the provision, but many prisoners thought that the range of material was not adequate. Prisoners could only go to the gym twice a week and the range of activities provided was insufficient.

1.28 There were not enough activity spaces to meet the needs of the population and the allocations process was inefficient. Leaders had not addressed most of the recommendations from the previous inspection and delivery was hindered by vacancies. Quality assurance processes had been discontinued. Leaders were not yet monitoring the effectiveness of new courses which they had commissioned.

1.29 The quality of education, skills and work had not improved sufficiently. In education, curriculum planning and needs analysis were not good enough, especially for prisoners released into the UK but not allowed to work. Vacancies in English teaching prevented delivery of a much-needed subject. In some areas teachers prepared lessons carefully

and effectively, but too few prisoners achieved qualifications in levels 1 and 2 mathematics and level 1 English.

1.30 Teachers developed vocational skills well, but teachers in classroom-based education received little training and they and peer mentors had not recently been trained to support prisoners with learning difficulties and disabilities.

1.31 Most prisoners behaved respectfully and courteously in learning and work activities and supported each other, for example in translating instructions. A small minority did not take learning seriously in education and were not encouraged by the teacher to work hard. Attendance was generally high, but too many prisoners did not arrive punctually for sessions.

1.32 Leaders and managers had introduced activities which focused on promoting prisoners' personal development, such as art, singing and a prison council, but tutors did not build personal and soft skills into the curriculum.

Rehabilitation and release planning

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

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

1.33 It took too long to book a visit and online booking was not yet available. Social video calls took place on some weekday evenings only and were usually fully booked. There were not enough slots to meet demand. In-cell phones were now in place, but there were no family visits and no family support service was operating at the time of the inspection.

1.34 Oversight of offender management work had improved recently and there was less cross-deployment of prison offender managers (POMs). Caseloads were manageable but the quality of delivery was inconsistent. The backlog had been reduced but some assessments were very overdue. Sentence plans were not always relevant or up to date. POMs' contact with prisoners had improved recently but was still not enough.

1.35 Public protection systems were good, with effective interdepartmental cooperation. The offender management unit contributed well to MAPPA processes in the community. Child protection procedures were well managed.

1.36 Re-categorisation reviews were often delayed while awaiting input from the Home Office. Many category D prisoners had long waits to move to open conditions and a few had been quickly returned from open prisons for tenuous reasons.

1.37 No accredited programmes were available and POMs found it difficult to arrange transfers to other prisons for prisoners to take courses. To help fill this gap, they carried out one-to-one work with about 60% of prisoners on subjects such as violence and victim awareness.

1.38 The resettlement needs of most prisoners who were to be released into the community were well identified, but resettlement staff struggled to meet those needs. Deportations under the early release scheme were often delayed, sometimes for long periods. About half the prisoners who the Home Office decided should be detained after their release date were given less than 30 days' notice. Prisoners did not have release plans and at best were signposted to support agencies. Some help was given by Citizens' Advice.

Notable positive practice

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

1.40 Inspectors found one example of notable positive practice during this inspection.

1.41 The drop-in health promotion sessions in the library were a positive initiative which was well received by prisoners. (See paragraph 4.53)

Section 2 Leadership

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

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

2.2 A clear and active lead was being given by the present governor, who had been in post for six months. She was very visible and her positive tone and realistic approach were appreciated by staff and prisoners. Her aims and priorities for the prison were clear, set out in a straightforward and positive self-assessment report, and staff were aware of her values. However, some areas of the prison had evidently suffered from lack of effective management or continuity in leadership.

2.3 Some staff, experienced and new in service, lacked competence and confidence in areas essential to safety, from use of force to the use of interpretation to understand individual risks and offer support to those who did not speak English. Leaders needed to provide training and monitoring to make sure that all staff were confident about basic operational procedures and that they understood the needs of many foreign nationals facing a very uncertain future. It was a serious issue that the lack of use of interpreting meant that prisoners' risks were not assessed or managed reliably and effectively.

2.4 Recruitment and retention of staff were a challenge for leaders and there was a shortage of officers, although this was not as acute as in some prisons. A number of important administrative functions were failing because of loss of staff through resignation, and insufficiently effective leadership. Reception, handling of complaints and applications, mail, parcels and family contact were all weak areas, although new systems had very recently been introduced in several of these areas.

2.5 Leaders had made progress in opening up the regime, which to some extent had restored the ethos of a training prison. However, staffing constraints led to inconsistencies in the regime and not enough time out of cell at weekends.

2.6 Some specialist areas of the prison were improving through committed individual leadership. These included health care and the probation-led work of offender management. The head of health care and the clinical leads for primary care and mental health worked together well which resulted in a reasonably good service, with better care for long-term conditions and shorter waiting lists for the dentist. Staff felt valued by the management team, with good training, development and supervision.

2.7 Leaders at Maidstone were working hard to help prisoners to make progress, even though they had no funding for programmes to address offending behaviour. The education provision, on the other hand, was weak and Ofsted colleagues at this inspection found serious shortfalls in leadership and management.

2.8 The old and unsuitable nature of several of the buildings, including some of the residential areas, presented a challenge to leaders, who were doing their best with a series of capital bids for improvement. Nevertheless, the standard of cleaning and of the outdoor environment mitigated the disadvantages, while the governor had driven improvement in the visibility of senior managers in prisoner areas, including regular checks on conditions and repairs.

Section 3 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

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

3.1 On average, 69 prisoners arrived at Maidstone each month. Staff did not routinely carry out a strip-search on arrival but used the body scanner to detect illicit items. However, all prisoners leaving for external appointments or transfer were strip-searched, which was unnecessary and not based on individual risk.

3.2 The reception area remained as unwelcoming as at the previous inspection. Little information was available and there was no material in other than in English. The holding rooms were clean but stark, with only a wooden bench and a small television. The rooms had no sanitation and prisoners had to ask staff to use the toilet. Reception staff could not easily observe prisoners in the holding rooms from the main staff desk and there was no CCTV. Reception and first night staff were polite, but some personal information, such as details of the offence and previous self-harming behaviour, was imparted at an open desk in earshot of other prisoners and staff.

3.3 Reception and first night staff did not use the contracted interpreting service for prisoners with no understanding of English and staff told us that there were no interpreting facilities in reception. Staff conducting the first night risk interview, which also took place in reception, were not therefore able to assess risk and vulnerability adequately. We observed staff using only hand gestures to try to communicate with a prisoner who could not understand English.

3.4 Newly arrived prisoners waited too long in reception before being taken to Weald wing, the induction unit. First night cells were adequately equipped but prisoners were only provided with a very thin blanket. New arrivals told us that they felt safe and were checked regularly during their first night.

3.5 Induction started the day after arrival in a group room on Weald wing. The presentation was delivered by enthusiastic peer workers who provided useful information but did not include how to make a complaint or application. The induction session was delivered in English with other prisoners interpreting for non-English speakers if they were available. This was disruptive for the rest of the group and it

was not clear what would happen if no prisoners were available to interpret.

Managing behaviour

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

Encouraging positive behaviour

3.6 The prison was generally calm. The level of violence had reduced since the last inspection and remained slightly lower than at comparable category C prisons. Most violence was not of a serious nature, although there had been 16 serious incidents during the previous year and one homicide which remained under police investigation at the time of our inspection.

3.7 Oversight of violent incidents was reasonably good. The weekly safety intervention meeting was a useful multidisciplinary forum for discussing prisoners who had been identified as posing concerns and planning appropriate interventions for them.

3.8 Leaders did not use data thoroughly enough to inform their safety policy. A considerable quantity of data was discussed at the monthly safer custody meetings, minutes of which showed that emerging patterns and concerns were identified and some actions taken in response, for example the disproportionate involvement of younger prisoners in violent incidents. However, it was not clear that all identified concerns had been addressed nor what the outcome of some actions had been. Not all the strategic priorities and actions in the prison's new safety framework were clearly linked to trends and concerns in the establishment.

3.9 In our survey, 31% of prisoners said they felt unsafe in the jail. Many prisoners attributed this to insecurity about their immigration status, but they were also concerned about antisocial and threatening behaviour, persistent problems with debt and an inability to understand and communicate in English. Physical violence was monitored and investigated reasonably well, but these concerns of prisoners and the accompanying risks were not as well understood and efforts to address them were inconsistent and not always effective. There was no strategy on bullying and threatening behaviour and we found several examples of prisoners raising concerns with staff which had not been adequately followed up and which, in some cases, had later escalated.

3.10 Challenge, support and intervention plans (CSIPs, see Glossary) had been introduced, but were mostly used to monitor perpetrators of violence. They were underused for victims and other prisoners of concern. The plans varied in quality and many did not demonstrate individual target-setting or meaningful interventions to support

sustainable changes in behaviour. At the time of our inspection, only one prisoner was self-isolating. Wing staff were offering him good support but he did not have a CSIP.

3.11 The incentives scheme worked reasonably well and prisoners were informed when positive or negative behaviour warnings were entered on NOMIS (electronic case notes.) Very few prisoners were placed on the basic regime and staff worked flexibly to encourage them to improve their behaviour and progress to a standard regime. However, many prisoners told us that there were few incentives to promote positive behaviour. Leaders were aware of this and had encouraged wing staff to acknowledge good behaviour by entering positive case notes. Monthly incentive forums had recently resumed and were attended by a senior manager, allowing prisoners to raise concerns about the scheme and suggest improvements.

3.12 An instant penalty process had been implemented for prisoners displaying poor behaviour to lose privileges in the short term such as in-cell televisions and access to parts of the regime. There was no oversight or monitoring of these ad hoc penalties to ensure that they were used fairly and leaders undertook to rectify this.

Adjudications

3.13 The number of adjudications had reduced sharply since the last inspection, with 634 in the previous 12 months. Hearings took place promptly and the backlog was small.

3.14 Adjudication records demonstrated sufficient investigation and charges were dismissed when there was not enough evidence. Prisoners who were adjudicated at the time of the inspection said they felt the process was fair and that they were given an opportunity to explain the circumstances. This was an improvement since the previous inspection. Punishments reflected the published tariffs, but cellular confinement was frequently imposed when other punishments could have been more appropriate. Leaders had started to review the use of punishments that reflected the underlying causes of offences.

3.15 The regular adjudication standardisation procedure did not show that the appropriate range of sanctions for each charge were considered. However, the governor conducted quality assurance of all adjudications each week and errors and inconsistencies were identified and addressed.

Use of force

3.16 The governance and oversight of force were weak. Senior managers reviewed paperwork and body-worn camera footage of incidents, but there was little evidence that poor practices were routinely identified or that lessons learnt were widely disseminated. Leaders had tried to address this by implementing a use of force scrutiny meeting with new terms of reference and broader attendance, but this was not taking place regularly at the time of our inspection.

3.17 Force had been used 107 times during the previous 12 months. Most of these incidents had been spontaneous, involving low-level guiding holds. Footage showed that many incidents were handled well, with staff working to de-escalate the situation. There were few planned interventions, but those that did take place were well organised, with good briefing and minimal force deployed.

3.18 However, we observed a number of more challenging incidents during which control and restraint techniques were deployed less well and force was used excessively and disproportionately with little attempt to de-escalate or communicate with the prisoner. On several occasions, handcuffs were used without adequate justification when a prisoner was offering no resistance and, in one case, actively saying he would comply. Another prisoner who was not resisting was handcuffed and carried down several flights of stairs. The prisoner lost consciousness several times during the restraint, but handcuffs were reapplied after he had received medical attention. The response by staff was poorly coordinated and some of the force used did not comply with approved techniques.

3.19 Until shortly before our inspection, all prisoners who were being moved to the segregation unit had been handcuffed with no risk assessment. On one occasion staff swore and shouted at a prisoner who was not resisting them.

3.20 Use of force documentation varied in quality and did not always provide a comprehensive account of events or adequate justification for the level of force used. Body-worn cameras were often not turned on until force had already been deployed so that the context and efforts at de-escalation were not routinely captured.

3.21 Batons had not been drawn during the previous year. We were told that special accommodation had also not been used over the same period, although there was evidence to suggest unauthorised use.

Segregation

3.22 The segregation unit remained a decent environment. The unit was clean and bright and cells were reasonably comfortable. Two constant supervision cells on the unit were no longer used for this purpose.

3.23 Segregated prisoners were able to exercise, shower and use the telephone each day. A small library on the unit included books in other languages and prisoners could access some in-cell activities, including workbooks.

3.24 In our survey, 77% of prisoners who had been segregated said that staff had treated them well. Prisoners who had been held on the unit at the time of our inspection were positive about their treatment and the support given by staff.

3.25 Segregation had been used 158 times during the previous year, a decrease since the previous inspection. The overall use was not

excessive, but two prisoners had spent long periods in segregation following recategorisation while they awaited transfer to another establishment. Staff had worked to give them the best possible regime while they were in segregation.

3.26 Multidisciplinary reviews of segregation were carried out regularly and all prisoners who had been segregated received a reintegration plan. The plans that we reviewed were brief with no meaningful, individualised targets and did not always identify interventions to support prisoners in improving their behaviour.

Security

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

3.27 Physical security arrangements were proportionate and aligned to risks. Prisoners could move freely around the grounds to go to and from work. However, too many prisoners were strip-searched with no assessment of their individual risks and the use of restraints on prisoners being escorted to hospital was not based on a proper assessment of individual risk.

3.28 Managers were aware of the key threats to security. The monthly local tactical assessment was good and provided an overview of key security concerns from the previous month. Minutes of the monthly security meetings did not demonstrate sufficient analysis of the available data or in some cases the identification of appropriate actions. This included exploration of the high mandatory drug testing rate and the availability of mobile phones and drugs.

3.29 The flow of intelligence into the security department was good. During the previous six months, 2,340 intelligence reports had been submitted. Illicit items, including drugs and mobile phones, and order and stability were the most consistent themes. Most intelligence reports were processed quickly but there were sometimes delays at weekends.

3.30 Leaders received effective support each month from the regional dedicated search team. Most targeted searches that were requested were carried out and during the previous 12 months finds had consisted of 88 mobile phones, 105 drugs, 18 weapons and 34 alcohol.

3.31 In our survey, 15% of prisoners said that it was easy to get drugs. Some measures had been introduced to reduce the supply of drugs, such as an itemiser to detect drugs on mail (see paragraph 6.7) and the use of a body scanner, but there was only occasional searching of staff as they entered the premises. Mandatory drug testing had been suspended from January to March 2022 and, since its reintroduction, the positive rate had been 21.82%, which was high. In August 2022 the

positive rate was 32.14% which was very high. Despite this, suspicion testing was not always carried out when required and 34% of suspicion tests had not been completed in the previous six months.

3.32 Links with the police were good and police intelligence officers worked well with the security team to manage gangs and identify extremists. Work to tackle staff corruption was very good. Prison managers worked effectively with the police when staff wrongdoing was suspected and this had yielded some positive results.

Safeguarding

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

Suicide and self-harm prevention

3.33 There had been one self-inflicted death since our last inspection. Some recommendations made by the Prisons and Probation Ombudsman (PPO) had not been achieved, for example the implementation of ACCT procedures (assessment, care in custody and teamwork case management of prisoners at risk of suicide and self-harm) and the routine handcuffing of prisoners going to hospital (see paragraph 3.27).

3.34 The rate of self-harm had increased since the last inspection from 148 to 173 incidents per 1,000 of population. During the previous 12 months there had been 98 incidents of self-harm, five of them serious. Another serious incident took place during our inspection.

3.35 Staff had not received enough training in the revised ACCT process and the quality of support was not high. We observed widespread anxiety and distress among prisoners, but a considerable lack of awareness of risk and identification of risk including when prisoners arrived at the prison (see paragraph 3.3). We observed a prisoner who disclosed on arrival that he had recently had a family bereavement, but this information was not passed on until we raised it. ACCT care plans were often missing or incomplete and in many neither risks and triggers nor sources of support had been identified. One prisoner said that he wanted a transfer because he was unable to see his family. He was told to complete a transfer request and apply for video calls, but there was no evidence that staff supported him in this. Another prisoner said that he felt under threat on the wing and staff told him to put in an application for a move to another wing rather than referring this to the safer custody team for investigation. Records of interaction with prisoners were often missing, different case managers attended successive reviews on occasion, and supervisors did not always complete their daily checks.

3.36 Complex cases were discussed at the weekly safety intervention meeting, but most of these concerned prisoners who had been involved in acts of violence or self-harm rather than identifying those who may be vulnerable for other reasons.

3.37 Some analysis of data had been carried out to develop a strategic approach to reducing self-harm, but further analysis was required to explore the causes and drivers of self-harm and take appropriate action.

3.38 In our survey, eight of the 15 prisoners who had been managed through the ACCT case management process said that they felt cared for by staff. Prisoners we spoke to who were currently or previously managed through the ACCT case management process had mixed views about staff support.

3.39 At the time of our inspection, there were 12 Listeners (prisoners trained by the Samaritans to provide emotional support to fellow prisoners). They spoke enthusiastically and positively about their role and the support they received from the Samaritans. However, they also expressed concerns about staff facilitating requests and said that prisoners regularly told them they had asked to see a Listener but were told incorrectly by staff that they were not available. In our survey, only 33% of respondents said that it was easy to speak to a Listener and on Weald, the induction wing, only 10% of prisoners said that it was easy. Prisoners consistently told us that they felt many staff did not support the scheme and did not always facilitate requests to see a Listener.

3.40 We observed some safety concerns during our night visit. Not all firehose reels were unlocked and ready for immediate use. In one case a member of staff was carrying a key which would not open the hose reel and some staff were unaware of the location of the inundation key (a key to open a small hole for a fire hose to put out a cell fire). Not all staff were clear about the circumstances in which they might enter a cell alone in the event of serious self-harm.

Protection of adults at risk (see Glossary)

3.41 The policy on adult safeguarding focused mainly on social care needs. With the exception of suicide and self-harm, there was no guidance for staff on how to identify vulnerable adults or how to protect them. There was no longer a direct link to the local adult safeguarding board, although the governor of another prison in the group attended the meetings on behalf of the group. Most staff were unfamiliar with safeguarding and associated procedures which increased the risk of failing to identify need.

Section 4 Respect

Prisoners are treated with respect for their human dignity.

Staff-prisoner relationships

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

4.1 In our survey, 69% of prisoners said they were treated with respect by most staff. We observed staff behaviour of varying quality towards prisoners: some very good engagement but some distant or passive interactions. Prisoners also described staff using their authority in a way that they perceived as veiled threats or an abuse of power. This was concerning.

4.2 The experience for prisoners who spoke little or no English was in many ways worse. They were rarely spoken to by staff in a language they understood and some felt isolated.

4.3 The atmosphere during movements and in wing association was relaxed. Supervision on some wings was restricted by poor sightlines and staff were not always visible in residential areas. Some low-level poor behaviour, such as vaping on wings, went unchallenged.

4.4 The leadership team was committed to improving the standard of key work (see Glossary). In our survey, 92% of prisoners said they had a named key worker but only 51% of those said they were helpful. Key work sessions rarely took place at the required frequency and the quality varied. Some entries in case notes reflected meaningful engagement but others were superficial. Staff often referred prisoners to other departments or advised them to submit applications or complaints rather than dealing with them directly. This contributed to high levels of frustration, notably when the applications and complaints systems were struggling to function effectively.

4.5 Leaders actively promoted the use of peer workers who filled a range of roles across the prison, including as information workers. However, there was little or no training or oversight of their work to make sure the information they shared was accurate. Information rooms on the wings were helpful but they varied in quality and the materials available.

Information room on Kent wing

4.6 The leadership team frequently issued notices to staff and prisoners to advise them of changes in the regime, but uniformed staff were sometimes unaware of or chose not to implement what was expected of them. This undermined improvements that leaders wanted to make.

Daily life

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

Living conditions

4.7 Most of the accommodation remained the same as at the previous inspection: an ageing establishment which, in parts, was barely fit for purpose. Leaders were, however, appropriately focused on making the living conditions as decent as possible within tight budgetary constraints and complex contractual arrangements. Some improvements since the last inspection included replacing the windows on Weald House, but more were required.

4.8 There was little overcrowding and most prisoners lived in single cells, which they appreciated. The relatively few double cells on Weald House were of a suitable size and furnished adequately.

4.9 Cells were generally free of graffiti, but many were cold and lacked toilet screening or lids and lockable cupboards. Some contained damaged furniture. Cells on Medway were particularly small while others across the prison were damp. Many windows were damaged and the temporary application of perspex screens to some windows offered protection from the elements. Many prisoners personalised and looked after their cells, but some were less well kept.

Personalised cell on Kent wing (left) and damaged window on Medway

4.10 Communal areas were clean and well maintained. All units had large indoor association areas with recently refurbished recreational equipment. The pest problem seemed to be largely under control and the grounds were pleasant. The open-air yard for each wing contained benches and basic exercise equipment.

Weald House exercise yard

4.11 In our survey, respondents were more positive about access to many basic amenities than at the last inspection and in similar prisons. Most prisoners told us they could access showers each day. Some shower rooms had been refurbished but many remained in an unacceptably poor state. Most prisoners wore their own clothes and many had their own bedding, which could be washed at least once a week in the prison laundry. There were enough stocks of prison-issue clothing and bedding.

Showers on Kent wing

4.12 Only 26% of prisoners who responded to our survey said that their cell bells were normally answered within five minutes. Prison data from July and August 2022 indicated that 10% of bells were not responded to within required timescales and some took much longer. Leaders were now checking response times regularly to address the issue.

Residential services

4.13 In our survey, only 42% of respondents thought the food was good compared with 60% at the previous inspection. Less than a third said that they had enough to eat.

4.14 Menus catered for the needs of a diverse population but were repetitive. Some menu options for the cold weekday lunches were small, but the hot dinners were more substantial. Meals continued to be served too early and the small breakfast packs were still distributed the day before they were due to be eaten.

4.15 Daily supervision of the meal service from wing serveries was ineffective: Halal tools were not always used and we saw servers vaping. Some practices, including transferring food from hot trolleys into cold trays, resulted in food being served below the required temperature, which was unsafe.

4.16 Self-catering facilities were limited to microwaves which, although appreciated, was inadequate for a category C population.

4.17 In our survey, only 32% of respondents said that the shop sold everything they needed compared to 59% in similar prisons. The list was adequate for most prisoners, but some popular items were repeatedly out of stock. Refunds for missing items often took too long and in many cases several months.

4.18 Many prisoners were dissatisfied with arrangements for making purchases from the small range of catalogues. Orders did not attract an administration fee, but fulfilment often took too long or the item did not arrive at all.

Prisoner consultation, applications and redress

4.19 Prisoners were extremely frustrated by the very poor response from the complaints and applications systems. Leaders acknowledged that they had been ineffective for a considerable time because of weaknesses in central administration systems and they had started to remedy the problem. Management of both areas had been poor but was improving, including the collation and analysis of data. The standard of responses to complaints was generally good and quality assurance was robust, but timeliness was still not good enough. There were signs of progress with complaints, but it was too soon to assess if changes made to the applications system would prove effective.

4.20 Consultation arrangements through the prison council, supported by Kinetic (a social enterprise working in the prison), were good. The council was championed by leaders and had influenced a number of meaningful changes, including increased access to private cash and installation of exercise equipment in the yards.

4.21 The legal services provision needed careful consideration. Most prisoners were very concerned about their immigration status and told us that the newly-established monthly Home Office immigration surgeries on each unit did little to allay concerns and fears or provide clear answers to their questions. Consultations with legal representatives now took place in private but facilities were often fully booked for weeks in advance. The library stocked a good range of legal texts, although only in English. There was limited oversight of the opening of legal mail and the reason for doing so was not always logged. Apart from Citizens' Advice, prisoners could not access free and independent legal support or advice, which was an omission for a category C prison.

Equality, diversity and faith

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

Strategic management

4.22 Oversight of equality had been maintained during the pandemic and the new governor had a strong commitment to this work. Quarterly diversity and inclusion meetings, chaired by the governor, covered a wide range of topics and were well attended. Prison-wide responsibility for promoting equality was improving, with named managers to lead on each protected characteristic (see Glossary) and the recruitment of peer equality representatives. Leaders had revitalised the equality action plan to include points raised in consultation with prisoners, but the plan was not always scrutinised at senior management meetings to make sure of steady progress.

4.23 Consultation with prisoners from protected groups had stalled during the COVID-19 pandemic. Forums for some protected characteristic groups had been reintroduced but remained intermittent. A diversity and inclusion survey had taken place just before our inspection, achieving a 50% response rate. Collection and analysis of data to identify potential disproportionality were good but did not always drive coordinated action planning to improve outcomes for prisoners.

4.24 During the previous 12 months, 28 discrimination incident report forms (DIRFs) had been submitted. Internal quality assurance measures for DIRFs had improved. The diversity and inclusion lead, and more recently the governor, reviewed all DIRFs which had driven improvements in the quality of investigations and responses, although these were not always timely. Prison leaders had recently engaged an external agency to check the quality of a sample of DIRF responses, but several prisoners had poor perceptions of the DIRF process.

4.25 Some good efforts had been made to mark cultural and celebratory events, such as Gypsy, Roma, Traveller History Month, Eid and Black History Month.

Protected characteristics

4.26 At the time of our inspection, there were prisoners from 79 nationalities speaking 55 different languages. A professional telephone interpreting service was available for those for whom English was not their first language, but staff did not always use it to discuss confidential or sensitive information (see paragraphs 3.3 and 4.48). Key documents, such as complaint forms and DIRFs, were available in other languages

but many staff did not know this and did not make enough use of translated documents on their computers.

4.27 In our survey, 55% of respondents identified as coming from a black or minority ethnic background and 29% were Muslim. They reported similar perceptions to white prisoners in most areas, although 59% said they had felt unsafe compared with 32% of white prisoners (see paragraph 3.9).

4.28 Several prisoners spoke of a lack of cultural awareness among some staff. A 'Cultural Awareness' booklet had been introduced to educate staff and prisoners, but none of the staff whom we asked was aware of it.

4.29 In our survey, 19% of respondents said they had a disability. Two cells had been adapted for wheelchair users and included wet rooms. One prisoner with a physical disability received assistance from a prisoner buddy. He was content with the support, but the buddy had not received training for the role. Twenty-two prisoners with neurodiverse conditions had been identified, but no consultative forum had taken place with either of these groups.

4.30 At the time of the inspection, 13 prisoners had personal emergency evacuation plans, not all of which were sufficiently detailed. Some staff on night duty were not aware of the needs of these prisoners.

4.31 About 39% of the population were aged 21 to 29 years. A recent young prisoners forum had identified a lack of suitable activities for this age group, but no action had been taken. Just over 9% of the population were over 50 and a few had reached retirement age. Little had been done to understand their specific needs or concerns.

4.32 At the time of our inspection, four prisoners from a Gypsy, Roma or Traveller (GRT) background had been identified. A GRT awareness event, open to all prisoners, had been held in June 2022 and was well attended.

4.33 In our survey, 5% said that they identified as homosexual, bisexual or other sexual orientation. A forum had been held in February 2022, but no action points had been identified. No links had been forged with local or national LGBT support networks.

4.34 Leaders knew of no transgender prisoners currently, although two respondents to our survey identified as such. Past case board reviews for transgender prisoners had demonstrated sensitive and appropriate care.

Faith and religion

4.35 The chaplaincy played a full part in the life of the prison, providing corporate worship, faith-based classes and good pastoral support, including seeing all new arrivals. Average attendance for Muslim prayers on a Friday was about 155 and the chapel and the multi-faith room were both used. In our survey, 90% of prisoners with a religion

said they were able to attend religious services if they wanted to compared to 69% in similar prisons.

4.36 The chaplaincy had been operating with staff shortages for some time, but there were now chaplains for most religions and almost all prisoners had access to a chaplain of their faith.

4.37 The chaplaincy facilities included a large chapel and a multi-faith room. The ablution facilities were not adequate and prisoners had to wash on the wings before attending services. The fabric of the chapel continued to deteriorate and some of the windows and roof were in a poor state of repair.

Interior of chapel

Health, well-being and social care

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

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

Strategy, clinical governance and partnerships

4.39 Following the integration of health care contracts for Kent prisons, in which Oxleas NHS Foundation Trust (Oxleas) had been identified as the main health provider from 1 April 2022, the quarterly partnership board had been combined for the six Kent adult prisons including HMP Maidstone. One meeting had taken place in this new format.

4.40 NHS England (NHSE) held quarterly contract review meetings and data reports were scrutinised before these meetings to inform the process.

4.41 There was good strategic partnership working between the prison, NHSE, including the public health lead, and health teams who also attended key prison meetings. Monthly governance meetings were held at which data were analysed.

4.42 The most recent health and social care needs assessment had been completed in September 2019 and a new assessment was planned in 2023.

4.43 Many aspects of health care services were reasonably good and clinics were running well with relatively low non-attendance rates. However, lack of oversight of referrals and follow-up to external hospital appointments had negatively affected the care and treatment that some patients received. A new procedure had been introduced in July 2022 which helped to improve monitoring, although the spreadsheet did not capture enough detail, including the dates that appointments had been followed up or responses received.

4.44 An experienced head of health care and clinical team managers were supported by a caring and conscientious staff group. The primary care team were on site from 7.30am to 7.30pm Monday to Thursday with shorter days on Friday and weekends.

4.45 Staff levels were now reasonable in most areas except in the psychological therapies team where staff had been recruited with imminent start dates. Gaps in the primary care team due to sickness were covered by known bank staff and managers provided clinical support if required.

4.46 All staff felt supported and received regular supervision. Compliance with mandatory training was good and professional development was encouraged with good uptake.

4.47 A clinical audit schedule had been implemented and improvements made as a result. Empowering People Inspiring Change (EPIC), an independent organisation, had completed patient surveys and patient feedback was collected to inform service developments. This was displayed in the form of ‘you said, we did’ posters.

4.48 A systematic approach to reporting and learning lessons from incidents informed clinical practice. Progress had been made with most of the health recommendations from the Prisons and Probation Ombudsman (PPO) death in custody reports. However, limitations remained in the

use of interpreting services which had also been highlighted by the PPO. Health staff made some use of telephone interpreting services, although this was not always their first option. They used Google Translate and other prisoners to interpret during confidential medical appointments, including reception screening, which was inappropriate.

4.49 Clinic rooms were clean and regular infection control audits showed good compliance overall, although the tap fittings remained non-compliant. This had been escalated to prison management and was awaiting attention.

4.50 A confidential health care complaint process was now in place, but a small number of the responses that we sampled were poor. They did not always fully address the issues raised, include an apology or demonstrate empathy for the patient. Action was not always taken in response to the complaint. None of the responses indicated how the patient could escalate their complaint if they were dissatisfied with the response. This needed to be addressed.

4.51 Health staff had received the appropriate life support training required for their role. The emergency equipment was in good working order and emergency drugs were in date, but some dressings were out of date and needed to be replaced.

4.52 Prison staff understood the code system to call for assistance in medical emergencies and the need for ambulances to be requested promptly. Each wing, reception and the segregation unit had a prison-owned automated electronic defibrillator in an easily identifiable alarmed cupboard which enabled rapid access. These were checked by the senior officer and recorded daily in the wing diary which was audited.

Promoting health and well-being

4.53 Oxleas had a health promotion strategy and followed a calendar based on national health initiatives. The health staff member identified to lead on this had been proactive in establishing drop-in health promotion sessions in the library and had created a health promotion folder including easy-read and translated material. These sessions had been well received. Some translated information was displayed in the health department, but more was needed.

4.54 The prison had a health promotion lead but available material was only in English, which limited its usefulness for those who did not understand written English. The pathway was still in its infancy and stronger links were needed with key services such as the gym, health care and the kitchen to provide a coordinated approach.

4.55 No prisoners had COVID symptoms at the time of the inspection. During the summer of 2022, an outbreak had been contained to one wing which public health said was well managed, using lessons learnt from previous outbreaks. The team were preparing for the autumn COVID and influenza vaccination programme.

4.56 National health screening programmes were available. Blood-borne virus testing, tuberculosis testing on an opt-out basis and vaping cessation clinics were offered to new arrivals. A hepatitis specialist nurse attended regularly to treat patients with hepatitis C. A respiratory nurse also attended regularly, which was positive.

4.57 Sexual health services were available and harm minimisation advice and supplies were available on an individual basis.

Primary care and inpatient services

4.58 A registered nurse screened new prisoners in reception using a national template to identify immediate health needs, including physical and mental health and substance misuse. However, we found that telephone interpreting services were not used consistently. Patients' health and social care needs were not consistently identified or documented at the initial reception screening or during their custody.

4.59 Prisoners received a comprehensive health assessment within seven days of their arrival and referrals to other services were made as required.

4.60 Prisoners could make health care appointments through paper applications, but many patients told us they frequently put in several applications before receiving a response.

4.61 Improvement had been made to the management of patients with long-term conditions. Regular clinics were held and staff had received additional training. Patients had care plans, most of which were individualised and appropriate for the patient's need.

4.62 A GP could be seen for an urgent consultation on the same day or within 14 days for routine appointments. Out-of-hours support was obtained through the NHS 111 system.

4.63 There was a good range of allied health professional clinics with relatively short waits for most services. A physiotherapist first contact practitioner role had been introduced to assess and refer to specialist services if necessary, such as orthopaedic services. This was working well.

4.64 External hospital appointments for a number of patients and orders for medical equipment for one patient were not managed well. We identified several patients, some with serious physical health conditions, who had been referred to external hospitals or equipment orders placed which had not been followed up. This considerably affected the health and well-being of some patients. A new system had been introduced in July 2022 which had improved monitoring although not all patients had been included on the monitoring system.

4.65 Pre-release consultations were arranged for patients being transferred or released and an appropriate supply of medication was provided if required. Patients released into the UK were given information on accessing health care services in the community.

Social care

4.66 There was no memorandum of understanding (MOU) between HMP Maidstone, Oxleas and Kent County Council (KCC), but partners met regularly to discuss service provision. A new regional MOU had been drafted for partnership approval before it was issued. No patients were receiving a package of social care at the time of inspection.

4.67 Although efforts had been made to promote understanding of the referral process, weaknesses were still identified. We found one prisoner using a wheelchair receiving support from another prisoner, who had not received any training as a peer worker. Neither health care nor prison staff had identified that support was required or made a referral to KCC. This was addressed immediately and the prisoner was moved to a cell adapted for disabilities. Two other patients with social care needs had not been identified promptly by the health care team, causing delays to referrals being made.

4.68 Seven referrals had been made to KCC in the last 12 months. Most assessments were carried out in a timely manner, but improvements were needed in recording actions taken following referral and the identification of potential need.

4.69 Equipment and aids were obtained via the occupational therapist at the local authority.

4.70 Peer workers (known as 'buddies') were recruited, trained and managed by the diversity and inclusion team to support prisoners with non-personal care. Only one peer worker was in place at the time of inspection.

4.71 The local authority, prison and health care discharge coordinator provided liaison and support to patients with continuing social care needs before transfer or release.

Mental health care

4.72 The mental health in-reach team (MHIRT) and the psychological therapies service delivered a stepped model of care for patients with mild to moderate mental health needs and those with more complex presentations, including patients with ADHD. They worked from Monday to Friday 8am to 4pm.

4.73 The MHIRT had been stretched but this had improved over the last few months. They were now fully staffed with experienced mental health nurses and delivered a responsive service. Patients spoke highly of the support they received from the team. The MHIRT was supporting 57 patients at the time of the inspection, including 21 with ADHD and 11 patients under the care programme approach, a framework designed to assess and support individuals with a mental illness. The psychological therapies service was supporting 11 patients.

4.74 There was an open referral system and new referrals were screened each day by a duty mental health nurse and any urgent requests

actioned within 48 hours. Routine referrals were assessed within five working days. A multidisciplinary allocations meeting was held each week to review and allocate new referrals to the clinician with the most appropriate skills.

4.75 The consultant psychiatrist visited once a week and the team prioritised the clinical need of patients waiting to be seen. Physical health checks were completed on patients on antipsychotic medication.

4.76 The psychological therapies services had recruited to fill vacant posts to reduce the lengthy waiting times for some therapies. The longest wait was 41 weeks for individual psychological therapy, with 14 patients on the list who were supported while waiting. A counsellor had recently started and a cognitive behavioural therapist and an additional psychologist were due to start imminently.

4.77 The assistant psychologist had started a compassion-therapy focused group which was co-facilitated by one of the mental health nurses. Two psycho-educational workshops in understanding trauma and emotional coping skills had also restarted.

4.78 A mental health nurse attended all ACCT reviews and visited prisoners in the segregation unit to offer support.

4.79 During the previous 12 months, one patient had waited too long to be transferred under the Mental Health Act to a secure hospital and another patient awaiting an assessment had exceeded the recommended guidelines. Excessive waits for transfers were escalated to commissioners each week and the regional transfer coordinator, to try to facilitate prompt transfers.

4.80 Clinical records that we sampled were good, with thorough risk assessments, comprehensive progress notes and care plans demonstrating patient involvement.

4.81 Mental health awareness training for officers had been curtailed and, while a few informal sessions had taken place, Oxleas were keen to re-establish this training as soon as possible.

Substance misuse treatment

4.82 The substance misuse service was delivered by Oxleas who provided clinical treatment and Change, Grow, Live (CGL) were subcontracted to deliver psychosocial support. Patients spoke positively about the care they received.

4.83 The revised format for health care services had started in April 2022 and full integration of the teams was still in progress as they were not co-located and used separate IT systems. Plans were in place to address this and there was good communication among staff to make sure that prisoners' needs were met.

4.84 The drug strategy was up to date and regular meetings were held to review data and intelligence to prioritise service delivery.

4.85 Newly arrived patients on opiate substitution treatment (OST) were stabilised and did not require detoxification, and clinical need was low. Six patients were in receipt of OST at the time of the inspection and treatment was flexible and reflected national guidelines. OST was administered competently by registered nurses who had undertaken specialist training in substance misuse. The medicine queue was well controlled by officers.

4.86 A new clinical substance misuse lead had been appointed. Prescribing reviews were undertaken jointly with the non-medical prescriber from HMP Rochester who visited weekly and a CGL staff member, which was positive. In the absence of the non-medical prescriber, a GP oversaw reviews and prescribing but more work was needed to develop an in-house service. Recovery plans were patient focused, but clinical care plans were not personalised. This had been identified by the head of health care as an area for improvement.

4.87 New referrals were seen in a timely manner by CGL and 86 prisoners were being supported. Staffing and recruitment had been a challenge, but key positions were now filled and caseloads were manageable. Referrals could be made directly by prisoners and staff. Support included harm minimisation advice, self-directed help including use of in-cell workbooks and one-to-one work.

4.88 Small group sessions had recently started. Staff focused individual support on prisoners identified for illicit drug use. Weekly mutual aid sessions were delivered by Alcoholics Anonymous. There were no peer workers but a peer coordinator had been recruited to identify and train new workers.

4.89 Release planning was in place and there was a newly recruited family worker. Naloxone treatment and training (to prevent opiate overdose) was offered to prisoners on an opt-out basis.

Medicines optimisation and pharmacy services

4.90 The delivery of some aspects of the pharmacy service were not effective. Medicines were dispensed remotely by an off-site pharmacy service. A range of emergency medicines were available for prisoners to access medicines out of hours.

4.91 Suitable over-the-counter medicines were available to treat minor ailments and other medicines via patient group directions (which enable nurses and other health care professionals to supply and administer medicines without a prescription). Staff were not following standard operating procedures to ensure that medicines were supplied and recorded safely.

4.92 Controlled drugs were well managed and audited regularly and medicines were transported securely. Records indicated that medicines requiring refrigeration were stored within recommended temperature ranges. However, similar records were not available for medicines stored at room temperature.

4.93 The prescribing of tradeable medicines was well controlled and only a handful of prisoners received them. The clinic led by the pharmacist, where advice could be sought on how to take medicines safely, and medicine use reviews were not available at the time of the inspection. A pharmacist was scheduled to visit the prison each month, but pharmacy staff shortages at other locations had prevented this from happening recently.

4.94 Medicines prescribing and administration were recorded on SystmOne, the electronic medical record. We saw a few prescriptions overlapped with the potential for patients to be administered more than the intended prescribed dose.

4.95 Most patients on prescribed medication received their medicines in possession. In-possession risk assessments were entered in the patient's medical record and reviewed as necessary.

4.96 Supervised medicines were administered twice a day. Supervision of medicine queues by officers was generally good and provided a degree of privacy, although this depended on the officer's understanding of the role. This had been raised by health care managers with prison managers. There was no provision for night-time administration, which was either given in possession or at 4pm. This reduced the therapeutic benefit.

4.97 Pharmacy technicians supported officers carrying out intelligence-led cell checks.

4.98 There were procedures to monitor patient compliance with treatment, depending on the type of medication. However, the non-collection of in-possession medicine was not consistently recorded or followed up and compliance in these cases was not always assured.

Dental services and oral health

4.99 Kent Community Health NHS Foundation Trust was subcontracted by Oxleas to deliver a full range of dental treatments. Four dental sessions a week were provided.

4.100 The health care and dental team triaged patients and offered pain relief if required. Oral health advice was given during appointments. Urgent referrals were seen at the next available clinic.

4.101 The dental service did not operate a recall system and patients were encouraged to put in an application when their next routine appointment was due. The service had worked hard to reduce waiting times which now averaged six weeks.

4.102 The dental suite met prevailing infection control standards. Equipment and maintenance schedules were up to date but the x-ray developer had not worked for some time and prison managers had been slow to replace it. In the meantime, the dental service had sourced a temporary arrangement to make sure that x-rays could go ahead. All

decontamination processes took place off site and were managed safely.

4.103 Patient records that we reviewed contained the required information and this was supported by recent audits.

4.104 The dental team did not have their own phone for interpreting services. As a result, clinics could overrun while a phone was sourced. This needed to be rectified.

Section 5 Purposeful activity

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

Time out of cell

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

5.1 Time out of cell had increased in recent weeks. Prisoners who were in full-time employment could spend seven hours 45 minutes unlocked from Monday to Thursday, compared to only four hours for those not employed. We observed inconsistent unlock times and, in our survey, only half the prisoners said that regime times were usually adhered to. Friday afternoon association was affected by the time taken to deliver canteen orders, which varied across different wings. There was no evening association and only 42% of prisoners in our survey said they could have association more than five days in a typical week against the comparator of 62%.

5.2 Our roll checks showed that more than half the population remained on the wing during the working day. Not all prisoners were attending activity placements when required. In our survey, 23% of prisoners from ethnic groups compared to 5% of white prisoners said they spent less than two hours out of their cell on a weekday, including at education and work. Allocation to activities was not being monitored.

5.3 As a result of low staff numbers, prisoners had a split regime at the weekend with limited time out of cell. Exercise yards contained benches and exercise equipment and prisoners were still able to move freely between the yard and the wing. However, only 44% of prisoners in our survey said they could go outside for exercise more than five days a week compared with 71% at similar prisons. Pool and snooker tables had been refurbished on the wings, but until the week of our inspection these had only been available at weekends.

5.4 Immigration detainees were no longer unlocked during the working day if they were unemployed. At our previous inspection detainees were given as much time out of their cell as possible, but this had reverted since the pandemic.

5.5 Access to the library remained limited to a half-hour slot during the working day. It was not open during the evenings or at weekends. Library staff were aware that not all prisoners were able to attend during this time and books could be ordered for delivery. Library rooms with a small selection of books had been created on the wings during the pandemic, but not all of these had continued.

5.6 Library staff collected data and used it in planning future provision. Some newly published books were available in a number of languages, but the room allocated was small and across all languages there was not enough to read: in our survey only 44% of prisoners against the comparator of 58% said that the library stocked a wide enough range of materials.

5.7 Literacy activities, including the book club, Reading Ahead challenge and Storybook Dads (prisoners recording a story to send to their children), had only restarted in recent months and the number of prisoners engaged in these activities was small. Seven Shannon Trust mentors (the Trust provides peer-mentored reading plan resources and training to prisons) were supporting 34 prisoners and actively promoting literacy.

5.8 The PE timetable offered two gym sessions a week to all prisoners, but this operated inconsistently and not every prisoner was allocated two slots. Many prisoners told us they wanted more time in the gym. Experienced PE staff worked well with health care to deliver remedial gym and sessions for the over-50s. There was still no analysis of which protected groups were using the gym.

5.9 There was not enough variety of sporting activities. No courses or qualifications were being delivered and no local community sport groups visited. The sports hall had been closed since the previous inspection, but a new hall was being built and due to open in the next year. The building work was taking place next to the astroturf pitch, which was also closed and no outdoor sports were taking place. Two gym areas were available with cardiovascular and weight equipment, some of which was new and in good condition. One of the gym areas was based in an old workshop building and did not have shower facilities.

Education, skills and work activities

This part of the report is written by Ofsted inspectors using Ofsted's inspection framework, available at https://www.gov.uk/government/publications/education-inspection-framework.

Ofsted inspects the provision of education, skills and work in custodial establishments using the same inspection framework and methodology it applies to further education and skills provision in the wider community. This covers four areas: quality of education, behaviour and attitudes, personal development and leadership and management. The findings are presented in the order of the learner journey in the establishment. Together with the areas of concern, provided in the summary section of this report, this constitutes

Ofsted's assessment of what the establishment does well and what it needs to do better.

5.10 Ofsted made the following assessments about the education, skills and work provision:

Overall effectiveness:	Inadequate
Quality of education:	Requires improvement
Behaviour and attitudes:	Requires improvement
Personal development:	Requires improvement
Leadership and management:	Inadequate

5.11 Leaders had not planned a curriculum that met the needs of all prisoners. The curriculum continued to focus on improving prisoners' essential skills in English, mathematics and information technology (IT). Vocational training was offered in areas such as construction, catering and cleaning to develop skills that prisoners could use to gain employment in their countries if they were deported, or in the UK if they had the right to work here. Leaders had not reviewed their curriculum offer to make sure that the levels and areas of vocational training offered were relevant to the needs of the prevailing prison population. They had not identified the resettlement needs of the significant minority of prisoners who were released into the UK and, in particular, of those who were not allowed to work, access benefits or study. They were not preparing these vulnerable prisoners well for release.

5.12 There were not enough spaces to meet the needs of the population and too many prisoners were unemployed. Leaders were not able to maximise the spaces available and a recent vacancy for an English teacher had prevented them from offering this much-needed subject. This in turn prevented those who wanted to become mentors but did not have the required level of English from joining the mentoring course. More than half the mentor positions at the prison were not filled. Lack of teaching cover through long-term sickness had resulted in some prisoners being transferred or released before they could complete their brickwork course.

5.13 The allocations process was inefficient. Staff did not allocate prisoners to the activities that had been identified as most appropriate for them given their starting points and their short- and long-term goals. For example, prisoners who had been identified as needing to join courses in English, IT user skills (ITQ) or catering were working in the laundry or the print shop. Leaders recognised that there were prisoners who had not had their starting points or future goals assessed and were working to clear a backlog in personal learning plans. At the time of the inspection, they had not been able to reduce the backlog.

5.14 The quality of education, skills and work had not improved sufficiently since the previous inspection and was not yet good. There had been a reduction in the number of qualifications prisoners could study for and

accredited training had not resumed in the industrial cleaning, waste management and horticulture areas after the COVID-19 restrictions were lifted. In mathematics and English for speakers of other languages (ESOL) entry level 1, teachers did not check prisoners' understanding effectively. They did not identify where prisoners had made mistakes in their work to help them improve. As a result, few prisoners improved their numeracy and English speaking, reading or writing skills in these courses.

5.15 In ITQ and higher entry levels of ESOL, teachers prepared lessons effectively. They focused well on helping prisoners acquire the skills, knowledge and confidence they needed to be successful in their subjects. Teachers questioned prisoners carefully to find out what they did and did not know and explained new concepts clearly. Staff developed prisoners' vocational skills well in construction, hospitality, laundry, recycling and gardens. Prisoners produced work to a good standard. Teachers in construction embedded English and mathematics well into both practical and theory lessons. Prisoners on vocational courses and on some education courses received useful feedback on their work that helped them improve.

5.16 Too few prisoners achieved qualifications in level 1 and level 2 mathematics and in level 1 English. Most prisoners achieved their ESOL and level 2 English qualifications. Prisoners achieved well on vocational courses that had external accreditation.

5.17 Staff did not identify prisoners' additional needs well or early enough for prisoners who needed support to receive it in a timely manner. Staff did not assess the initial needs of all prisoners and, when they did, the information they gathered did not always reach teachers who did not find out about the additional needs of some of their learners until they were already in lessons.

5.18 A small number of prisoners studied high-level courses through distance learning and Open University courses. They benefited from good support from education staff and access to the virtual campus (prisoner online access to community, education and training opportunities) for their studies. Other prisoners such as prison council members used the virtual campus to type minutes of meetings. Teachers did not use the virtual campus resources for their lessons.

5.19 The prison education framework (PEF) provider, Weston College, had carefully selected the content and structure of the education and vocational courses they were running. Teachers started by introducing basic concepts and increased the complexity of tasks as prisoners became more confident in their skills and knowledge. As a result, prisoners learned new topics in a logical and sensible order. Teachers were experienced and appropriately qualified for their roles although the quality of their lessons varied. While some teachers were skilled at explaining new concepts effectively and checking prisoners' understanding, others did not involve prisoners enough in lessons or identify prisoners who made mistakes in their work. As a result, the

quality of prisoners' work and their achievement were not consistently good across courses.

5.20 Teachers did not receive training frequently enough to help them improve their teaching skills. Few teachers were aware of what they could do to improve their classroom practice. Teachers and peer mentors had not received any recent training on supporting prisoners with learning difficulties or disabilities.

5.21 Considerable staff changes and vacancies had affected the ability of leaders to manage the education, skills and work area effectively. They had only achieved one of the 12 recommendations from the previous inspection. Staff had not had the capacity to continue with most of the quality assurance and performance management processes that had previously been in place or to introduce new ones where needed. Prison managers did not quality assure the education, skills and work offer beyond the contractual management meetings with the PEF provider. Leaders had yet to introduce processes for monitoring the effectiveness of the new subcontracted provision of personal development courses. Leaders and managers did not use data well enough to evaluate the effectiveness of the curriculum.

5.22 Leaders did not have a reading strategy in place to promote reading across the prison. There was no focus on improving the fluency and confidence of prisoners' reading abilities. For example, in pre-entry ESOL, the teacher did not give prisoners strategies to help them quickly improve their reading or pronunciation. Prisoners did not practise reading key words enough to improve their fluency. Prisoners with low levels of literacy benefited from support from trained Shannon Trust mentors. However, leaders recognised that mentors were not appropriately equipped to support prisoners whose first language was not English.

5.23 Attendance at education, skills and work activities was generally high, although too many prisoners did not arrive punctually. Prisoners behaved respectfully and courteously in learning and work activities. The atmosphere was typically calm and conducive to learning. A small minority of prisoners in education did not take their learning seriously. Where this occurred, teachers did not encourage these prisoners to work hard and they achieved little in lessons. Prisoners felt safe while attending education and work activities.

5.24 Peer mentors supported prisoners well during their induction and careers interviews under close supervision by staff. However, mentors did not receive sufficient training for these advisory roles. For example, none of the peer mentors supporting induction was studying the appropriate mentoring or information, advice and guidance qualifications available to them.

5.25 Leaders had commissioned a range of subcontractors to offer useful activities focusing on the personal development of prisoners, such as art, singing and support for prisoner representatives at the prison council. There were limited opportunities for prisoners not engaged in

these activities to develop their knowledge and skills beyond the subjects they were studying. Staff did not plan for the development of prisoners' personal and soft skills in the curriculum (non-technical skills used to interact with others, such as social and communication skills and emotional intelligence). Furthermore, they did not actively support prisoners to develop their understanding of British values. However, prisoners were respectful and tolerant of staff and their peers.

5.26 In too many areas, staff did not identify and record the development of prisoners' soft skills. In areas where staff were doing this well, such as laundry, prisoners recorded their own progress and managers confirmed the new skills that prisoners had learned and reviewed their progress against the targets they had set.

5.27 Teachers and instructors motivated prisoners skilfully, for example in recycling prisoners were given information on the environment and saving resources. In art, prisoners explored issues that they would ordinarily find difficult to talk about, such as bereavement. As a result, prisoners enjoyed their work and saw the value in what they were doing.

5.28 Pay rates were higher in education and vocational training than for work. Education courses were part time and prisoners could combine education and work to avoid being financially disadvantaged.

Section 6 Rehabilitation and release planning

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

Children and families and contact with the outside world

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

6.1 A new family and significant others policy had been drawn up but not yet implemented. It provided information for families and prisoners about the visits process. It did not link with the strategy for reducing reoffending and was not informed by consultation with prisoners, even though the resettlement department had completed a good needs analysis that included data about visits.

6.2 Visits took place four times a week, including Saturday and Sunday, between 2 and 3.30pm and were almost always fully booked. Maidstone was a national resource to which prisoners could be sent from almost anywhere and some families faced long journeys for a comparatively short visit. To compound this, both prisoners and visitors told us that visits did not always start on time and visitors were sometimes delayed getting into the prison, further reducing the time that prisoners could spend with their families.

6.3 Visits could only be booked by telephone and prisoners and their families told us it could take days of repeated calling to get through and book a visit. Leaders had responded to this by the recent recruitment of an additional booking clerk and online bookings were to be available in the near future.

6.4 The social video calls area was well appointed with five booths of appropriate size that provided good levels of privacy. Social video calls were also fully booked, sometimes weeks in advance. Two one-hour sessions were available each evening from Monday to Thursday. Each wing was allocated a different night so that prisoners on larger wings had less opportunity for a video call. Demand outstripped availability and leaders agreed that there was scope to increase the number of video calls.

6.5 The contract for work with children and families had recently been renewed and all family support work had stopped during the transition to the new provider. The previous provider had delivered good services including help for prisoners to reconnect with their families, self-study

packs in various subjects and birthday gifts for prisoners' children. These services were to continue under the new contract.

6.6 Family visits had also ceased but were in the planning stage for later in 2022. Female visitors and children, including babies, were given wrist bands to identify them and prevent them swapping places with prisoners, which was unnecessary. Leaders responded quickly to our feedback during the inspection and this practice was stopped.

Children's area in visits hall

6.7 Mail was frequently delayed as too few staff knew how to use the itemiser which detected illicit substances hidden in the mail. These delays could be more than a week and sometimes up to three weeks, which was unacceptable.

Reducing risk, rehabilitation and progression

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

6.8 Management of the offender management unit (OMU) and of resettlement was in transition but had improved recently. The senior probation officer had recently returned from maternity leave but the interim arrangements during her absence had not delivered enough quality assurance or support. The head of resettlement post had been left vacant for some time following a temporary promotion and was due to be filled imminently.

6.9 The reducing reoffending strategy had very recently been rewritten. It was of good quality and informed by a good needs analysis which the resettlement department conducted each year. However, the accompanying action plan contained elements dating back years in some instances and was not driving improved resettlement outcomes for prisoners.

6.10 Prison offender mangers (POMs) were now ringfenced and rarely cross-deployed to cover in other areas. Caseloads were proportionate, with the three probation POMs managing most of the high-risk cases. Case administration was almost fully staffed and the spread of work was appropriate.

6.11 A team of immigration staff from the Home Office were co-located in the same large office, which helped to form good links between POMs, case administration and Home Office staff.

6.12 The monthly reducing reoffending meeting was well attended and identified current priorities for all the major stakeholders. However, there was no up-to-date structured action plan or strategy and some long-running issues in resettlement persisted.

6.13 In the OASys (offender assessment system) assessments that we examined, we found that 13 out of 20 prisoners had an OASys that was dated within the last year and the backlogs noted at our previous inspection had been reduced. This was an improvement, but some were still overdue, a small number considerably. Every completed OASys had a sentence plan, most of which were reasonably good, but progress against these plans was inadequate in at least half the cases that we reviewed.

6.14 Every sentence plan had multiple targets, most frequently for offending behaviour programmes (OBPs) or the need to be assessed for one. These were rarely achieved (see paragraph 6.26). Other targets such as substance misuse work, employment and training were more regularly achieved but there was an over-reliance on behavioural targets rather than reducing risk. Some plans were out of date and in need of review and most prisoners had not made enough progress against their sentence plan.

6.15 Contact between POMs and prisoners varied considerably, but overall contact was not good enough. Cases were promptly and appropriately allocated and we generally saw evidence of early contact by the POM. Thereafter contact varied and tended to be process driven or generated by events such as report writing or an imminent handover to the community. Most of the prisoners we spoke to were unable to name their POM or say with confidence that they had a sentence plan.

6.16 Risk management plans were reasonably good for prisoners assessed as a high risk of reoffending or of harm to the community. The best examples were written by Maidstone POMs and they contained clear actions, with useful contact numbers and addresses.

6.17 Key working (see Glossary) was inconsistent and we saw better and more informed entries for higher-risk prisoners. Key work did not support sentence planning, however, and there was no mention of progression against targets in any of the key work entries that we reviewed.

6.18 Home detention curfew (HDC) could only start when the Home Office confirmed that the prisoner was no longer of interest to them. OMU staff responded quickly in processing the necessary risk assessments and gaining approval. During the previous 12 months, four prisoners had been granted HDC and all were released within four weeks of Home Office confirmation.

Public protection

6.19 Public protection processes were good. OMU staff checked appropriately that the originating prison had carried out correctly the necessary checks for child protection and harassment orders and completed those that had been missed. Applications for child contact were dealt with swiftly and monitoring was reviewed regularly so that prisoners were not monitored for extended periods when they did not pose a risk.

6.20 The interdepartmental risk management team meeting (IDRMT) took place monthly and was well attended. Key agencies such as mental health and the Home Office were present and there was a good level of input into each case. The meeting identified key areas of concern, particularly in release arrangements, and generated suitable actions to reduce the risk.

6.21 In some cases, POMs encountered delays by community offender managers (COMs) in identifying the MAPPA level of prisoners (multi-agency public protection arrangements). This should be done about seven months before release, but COMs did not always prioritise these cases because of the uncertain immigration status of some prisoners. It was clear that POMs followed up these decisions and started the resettlement process at a suitable point, but it was concerning that procedures for the release of the highest risk prisoners could be compromised by these delays.

Categorisation and transfers

6.22 POMs started the recategorisation process on time but were hampered by delays in responses from the Home Office. Prisoners could only be sent to open conditions if they still had an avenue of appeal against any deportation decision and before the issuing of a notice to detain. This was not clearly understood by staff in some open prisons who routinely returned prisoners inappropriately because they were of interest to the Home Office.

6.23 The situation was improving and recently more prisoners had been successful in reaching open conditions, although still only 10 prisoners had been moved in the last 12 months.

6.24 Prisoners held under immigration powers had to be moved to an immigration removal centre (IRC) or back to remand conditions so that they could access the level of regime that they were entitled to. This usually took place in a timely manner, but delays occurred when a prisoner was deemed to be too high a risk for an IRC, or when prisons holding remand prisoners were full.

6.25 Prisoners who volunteered for the early release scheme, who received a 12-month reduction in sentence for agreeing to be deported, were often delayed, sometimes for months, which considerably undermined the scheme and reduced its effectiveness. Many prisoners complained to us about this.

Interventions

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

6.26 No offending behaviour programmes were carried out at Maidstone despite this being the most common area identified in sentence planning. POMs tried to get prisoners with the greatest need transferred to a prison that delivered the required programme, but this was difficult and POMs were frequently frustrated in their efforts. A recent example concerned a high-risk prisoner who required the Kaizen course (addressing general violence) successfully transferring to a category B prison, only to be sent back the next day as he was deemed not suitable, apparently for no good reason. Prisoners could be released into the community without effectively addressing their identified areas of risk.

6.27 POMs carried out good one-to-one work with about 60% of their prisoners. This work encompassed a wide range of topics such as Choices and Changes, a programme for prisoners under 25 to help them make better decisions, victim awareness and Maps for Change which looked at the impact of violence.

6.28 Release on temporary licence (ROTL, see Glossary) was not used and no prisoners had been released on ROTL during the previous 12 months.

6.29 Citizens' Advice (CA) delivered a remote service to which the resettlement team referred prisoners. This service was well used and during the previous six months 169 prisoners had had contact with CA, the vast majority concerning legal issues. CA had written 359 letters on behalf of prisoners. Citizens' Advice confirmed at the time of the inspection that they would be returning to the prison to see prisoners face to face.

Release planning

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

6.30 During the previous 12 months, 203 prisoners had been released into the community, most of whom went to resettlement areas away from the prison.

6.31 The resettlement team was under-resourced. The manager had been temporarily promoted and the post had not been filled. The department should have had two full-time prison officers but they had been re-allocated to other duties, leaving one member of staff in the department.

6.32 A good needs analysis of the population was conducted each year and the team was well versed in the resettlement needs of the prisoners.

6.33 We were told that the Home Office immigration team was working to a target of informing every prisoner at least 30 days before their conditional release date whether they would be released or detained at that date. The target was not met in many cases and 43% of prisoners were told of the decision less than 30 days before their expected release date. Thirteen per cent were given less than seven days' notice. These delays affected the ability of the resettlement team to meet the release needs of prisoners.

6.34 At the time of the inspection, about 30 prisoners were held under immigration detention powers following the end of their sentence, most of whom were moved quickly to an IRC or local prison. One prisoner had been granted bail, but no suitable accommodation had been found for him, extending his time in prison.

6.35 Prisoners' resettlement needs were identified on arrival using a bespoke preparation for release booklet that covered the seven main resettlement pathways. This was reviewed three months before release. A peer worker offered support to prisoners throughout this process and resettlement staff advised prisoners of agencies and charities which could help with their concerns. The booklets were only available in English and prisoners for whom English was not their first language had to rely on their peers to translate for them.

6.36 The resettlement team recycled clothing for prisoners who did not have suitable clothes for release, an initiative which was well used and appreciated by prisoners.

6.37 Housing was the responsibility of the COM until a prisoner's conditional release date, when the responsibility moved to the Home Office. The delays in decisions about detention sometimes gave COMs insufficient time to plan suitable accommodation. Resettlement staff referred prisoners to housing agencies, but this uncertainty generated anxiety

for those due to be released. On too many occasions housing was not found and, over the previous 12 months, 12 prisoners had been released with no suitable accommodation and were classed as of no fixed abode. One of these prisoners was assessed as being at high risk of reoffending.

6.38 Prisoners released from Maidstone were nearly always on immigration bail, so did not have the right to work. The Department for Work and Pensions no longer attended the prison and prisoners were not given benefits advice other than by Citizens' Advice.

6.39 Little information was given to prisoners being deported. Tracks, an online toolkit, gave practical information on resettlement in several countries, but this was underused and the information booklets provided by the Home Office were rarely seen by prisoners. Home Office staff held monthly drop-in centres on the wings to answer prisoners' queries which was helpful but too infrequent to meet demand.

Section 7 Summary of priority and key concerns

The following is a list of the priority and key concerns in this report.

Priority concerns

1. **Staff did not have enough understanding of or react effectively to the particular needs of the population of this jail in which prisoners were often vulnerable, anxious and distressed.**

2. **Professional interpretation services were not used enough.** The experience of those who spoke little or no English was poor.

3. **The systems for dealing with prisoners' applications and complaints were ineffective and were the cause of much frustration.**

4. **External hospital appointments and orders for medical equipment were not managed well.** Staff had not followed up some important referrals and orders for equipment, with negative effects on the health and well-being of some patients.

5. **There were not enough staff in education, skills and work to plan and teach a curriculum that fully met the needs of the population and to bring about the necessary improvements in quality and performance.** Leaders had not reviewed their curriculum offer to make sure that it was of high quality and relevant to the needs of the population.

Key concerns

6. **The oversight and scrutiny of the use of force were weak.** Poor practice was often not identified and learning from incidents was not passed on to staff so that they could improve their performance.

7. **Too many staff were passive or distant in their interactions with prisoners.** Key work sessions were not frequent enough, nor always properly focused or helpful in dealing with the individual's issues.

8. **Although there had been some improvements to living conditions, some parts of the estate were barely fit for purpose.** Some cells were too small, damp and cold with damaged windows, no toilet screening and damaged furniture. Many showers were in a poor state.

9. **The food was unpopular with prisoners and had deteriorated since the last inspection.** Some poor practice in the serving of meals prejudiced food safety.

10. **The delivery of some areas of the pharmacy service was not effective.** In the absence of adequate professional oversight, there were some deficiencies in the recording and control of the use of medicines.

11. **Leaders and managers had not improved the quality of the education, skills and work provision to bring the teaching that prisoners received to a good standard.** The quality of education and vocational lessons was too variable. Some teachers did not check learning effectively and did not support prisoners to improve their knowledge and skills.

12. **Leaders did not ensure that prisoners accessed education, skills and work activities appropriate to their identified needs, in a timely and sequenced way.** Staff did not allocate prisoners to the activities identified as most appropriate for them. Leaders did not maximise activity spaces and more than a fifth of prisoners were unemployed.

13. **There were no programmes to address offending behaviour.** Many prisoners needing such a course could not move to a prison which delivered it. As a result, they were unable to progress with their sentence.

14. **Prisoners' resettlement needs were not always met, especially in key areas such as housing and benefits, despite good systems to identify them.**

Care Quality Commission regulatory recommendation

Providers should have suitable systems and processes in place and should make sure that they are implemented effectively.

Section 8 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy prison.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection in 2018, reception staff were polite but did not use telephone interpreting when necessary. First night staff did not assess prisoners' risks and there were no first night checks. Induction was adequate. The prison was orderly and calm and the number of violent incidents was low. The adjudication and incentives and earned privileges (IEP) processes were fair and the IEP forums were good practice. Force was rarely used and incidents were well managed. Men spent too long on the segregation unit awaiting transfer to category B prisons. Prisoners were not routinely invited to their segregation review boards. Security arrangements were generally proportionate but some practices were not. Drug use had increased but had not destabilised the prison. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendation

Reception and first night processes should ensure that prisoners' immediate vulnerabilities, needs and risks are thoroughly assessed through a private interview with prison staff to ensure that appropriate support is offered. Additional night time checks should be undertaken on new arrivals.
Partially achieved

Recommendations

Prisoners on escort should be given adequate toilet breaks and this should be recorded.
Achieved

Prisoners on the first night centre should be unlocked during the core day.
Not achieved

The induction programme should be clear, concise and relevant and should provide all prisoners with enough knowledge to access fully services and activities at Maidstone. This should include contact with Home Office staff.
Partially achieved

Procedures to monitor perpetrators of violence or antisocial behaviour should address the underlying causes of violent and antisocial behaviour and set targets specific to the prisoner.
Not achieved

Detailed analysis of adjudications should be carried out to identify themes or trends and to reduce the quantity of laid charges.
Partially achieved

Prison managers should review and quality assure all incidents of force, associated video footage and documentation.
Not achieved

The special cell should be made fit for occupation or taken out of use.
Not achieved

Good order or discipline and reintegration planning reviews should be attended by staff from relevant departments and should focus on the prisoner's individual circumstances. The prisoner should be invited to attend.
Partially achieved

Cells for prisoners requiring constant supervision should not be located in the segregation unit.
Achieved

The strip-searching of all men leaving the prison and the handcuffing of all prisoners going to hospital should be proportionate and based on an individual risk assessment.
Not achieved

Intelligence-led searches should be carried out quickly in all cases where a need is identified.
Achieved

The MDT suite should have a separate key and should only be accessible to those undertaking MDT work.
Achieved

The MDT suite should be sterile and conducive to forensic testing.
Achieved

The MDT suite holding rooms should be refurbished and heating installed.
Achieved

Random mandatory drug tests should be unpredictable, and suspicion and risk-based testing should be completed promptly in relevant cases.
Not achieved

ACCTs should be of a consistently good quality, ensuring that individual prisoners receive appropriate care and support.
Not achieved

There should be a policy for the thorough investigation of all serious incidents of self-harm and action on learning points and recommendations. The policy should include implementation of recommendations in Prisons and Probation Ombudsman fatal incident reports, and these should be reviewed regularly.
Not achieved

There should be a coherent strategy to reduce self-harm, informed by the characteristics of the population at Maidstone, and meaningful analysis of data including contributions from key partners such as health care and the Home Office.
Partially achieved

Prisoners on ACCTs should be located in the segregation unit or special accommodation only as a last resort and in exceptional circumstances. When prisoners are located in this area, defensible decisions logs should show full justification for the reasons and alternatives that have been explored.
Partially achieved

All staff should be trained in safeguarding procedures and be aware of their responsibilities.
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection in 2018, staff-prisoner relationships were generally good. Residential units were old and shabby but they were largely clean and tidy. Outside areas were good. Laundry services were poor and caused a lot of frustration. Food was good. Arrangements for consultation with prisoners were good. Responses to complaints had improved and were now adequate. Equality and diversity work still required development to address areas of potential discrimination. Faith provision was limited but attendance at corporate worship was excellent. Health services were reasonably good but dental services and the management of long-term conditions were inadequate. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendation

Sufficient investment should be made to ensure that the prison provides a safe and decent environment for prisoners and facilities which are fit for purpose.
Partially achieved

Recommendations

Officers should make regular, detailed and informative case note entries which comment on sentence plan progression and welfare.
Partially achieved

All showers should be adequately ventilated and decorated. All toilets should have lids and seats and be appropriately screened.
Partially achieved

Water should be at an appropriate and consistent temperature for taking showers.
Partially achieved

Adequate laundry arrangements should be in place for all prisoners.
Achieved

Menus should be sufficiently varied and should be assessed for nutritional content.
Partially achieved

Meals should be served at times equivalent to those in the community.
Not achieved

All catering equipment should be repaired quickly.
Partially achieved

Information peer workers should receive formal training with appropriate staff oversight to ensure that accurate and consistent information is provided to prisoners.
Not achieved

Complaint forms should be available in a range of languages next to complaint boxes which are clearly labelled and prominently located. Responses to complaints should be timely.
Partially achieved

Prisoners should be able to consult their lawyers in private.
Achieved

Local data should be routinely analysed to identify unfair treatment of protected groups in key areas, and corrective action should be taken to address inequality.
Partially achieved

Investigations into discrimination incidents should be timely and comprehensive and subject to robust independent quality assurance.
Partially achieved

Prisoners should be able to disclose their protected characteristics in confidence.
Not achieved

Material in the most common foreign languages should be freely available and well signposted across the prison.
Partially achieved

Telephone interpreting should always be used for sensitive and confidential interviews.
Not achieved

Regular clinical audits should be completed to assess and monitor the quality and safety of services.
Achieved

A separate confidential health care complaints process should be clearly advertised and available on the wings.
Achieved

Cross-disciplinary integration and strategic oversight should be implemented to achieve integrated working and stronger governance arrangements.
Achieved

Health care clinical areas should be refurbished to meet infection control standards.
Achieved

Emergency drugs and equipment should be in accordance with resuscitation council guidelines.
Achieved

There should be an overarching health promotion strategy and multidisciplinary action group to inform activities.
Partially achieved

Prisoners with long-term health conditions should receive regular reviews by appropriately trained staff, informed by an evidence-based care plan.
Achieved

There should be a whole-prison approach to improving the understanding and implementation of the social care pathway supported by a local memorandum of understanding.
Not achieved

Transfers to hospital under the Mental Health Act should take place within Department of Health transfer target timescales.
Not achieved

Methadone should be supplied in an environment that ensures the safety and security of staff.
Achieved

Prisoners with dual diagnosis or multiple pathologies should receive integrated care.
Achieved

All health staff responsible for administering medication should review and sign any relevant policies and patient group directions.
Achieved

Prisoners should have access to routine dental appointments within six weeks.
Achieved

Purposeful activity

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

At the last inspection in 2018, prisoners could spend a good amount of time out of their cells. The library service was limited but reliable. The loss of the sports hall severely limited men's physical education. Since our last inspection, most education, skills and work provision had deteriorated. Many courses did not meet prisoners' employment needs and many prisoners did little or nothing in workshops. Waiting lists to join the small number of vocational training courses were very long. Too few prisoners gained useful employment or personal skills and left the prison no better equipped than when they arrived. Outcomes for prisoners were poor against this healthy prison test.

Key recommendations

Leaders, managers and staff should focus relentlessly on implementing effective new continuous quality improvement arrangements which are informed by a comprehensive and accurate evaluation of all areas of weakness in education, skills and work.
Not achieved

Leaders and managers should ensure that all work activities develop prisoners' employment and personal skills and lead to qualifications and clear records of achievement.
Not achieved

Leaders and managers should implement a thorough and accurate training needs analysis of the population, use it to implement a full curriculum review and ensure that the provision of activities meets the needs of the majority of prisoners, including the more able and experienced.
Not achieved

Recommendations

All prisoners should be unlocked for both the morning and afternoon at weekends.
Not achieved

Attendance at the library and gym should be monitored and analysed consistently to develop provision.
Partially achieved

Leaders should ensure that the available data are analysed in depth and form the basis of effective performance management and monitoring.
Not achieved

Staff absence or vacancies should be covered so that course cancellations are the exception.
Not achieved

Managers should ensure that appropriate and effective resettlement courses are available to all prisoners nearing release.
Not achieved

Managers should gather information on prisoners' entry to employment, training or education after release.
Not achieved

Leaders and managers should ensure that the quality of teaching and learning improves rapidly and becomes at least good.
Not achieved

Leaders and managers should ensure that prisoners have good opportunities to develop their personal and employment skills and behaviour.
Not achieved

Leaders and managers should ensure that prisoners value and participate fully in learning, skills and work and see it as the main route to rehabilitation.
Partially achieved

Leaders and managers should ensure that the great majority of prisoners on accredited courses start, complete and achieve their qualification.
Achieved

Leaders and managers should ensure that prisoners leave the prison better qualified and more employable than when they arrived.
Not achieved

Rehabilitation and release planning

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

At the last inspection in 2018, visits arrangements were adequate. Work to support family ties had improved but was not yet fully developed. The strategic management of resettlement had improved since our last inspection. About half the prisoners did not have an up-to-date offender assessment system (OASys) assessment. Preparation for release had improved but not all resettlement needs were met. Some men were informed very late that they would be detained under immigration powers.

In practice, almost no prisoners benefited from home detention curfew, temporary release or re-categorisation. No interventions were offered to manage offending behaviour. 'Steps to the gate' was a good initiative but the resettlement workshop was not yet effective. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendation

Organisation and delivery of rehabilitation and release planning services should be integrated into a single coherent system that identifies and addresses the risks and needs of each prisoner throughout their time at Maidstone. In particular, all prisoners should have an up-to-date OASys assessment and sentence plan and should be supported and motivated by regular and meaningful contact with offender supervisors.
Not achieved

Recommendations

Immigration caseworkers should make decisions about a prisoner's removal or release promptly to help target and maximise the effectiveness of resettlement work.
Not achieved

There should be sufficient staff in the offender management unit to undertake regular, proactive casework with all prisoners.
Achieved

There should be sufficient Home Office immigration enforcement officers to facilitate regular, proactive casework with all prisoners.
Achieved

Foreign national prisoners should be risk assessed for category D status, open conditions, home detention curfew and release on temporary licence through processes which give them a fair chance of achieving these forms of progression in their sentence.
Achieved

The various schemes designed to support prisoners who receive few or no social visits should be actively promoted in the most popular languages and their use monitored.
Not achieved

There should be a range of programmes and one-to-one offending behaviour work, including victim awareness, to meet evidenced need.
Not achieved

Preparation for release should be developed into a coordinated procedure available to all prisoners, including effective provision of information to support resettlement in another country.
Not achieved

Appendix I About our inspections and reports

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

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

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

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

Respect
Prisoners are treated with respect for their human dignity.

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

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

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

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

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

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

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

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for prisoners. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

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

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

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

This report

This report provides a summary of our inspection findings against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 5, 2017) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/). Section 7 summarises the areas of concern

from the inspection. Section 8 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

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

Inspection team

This inspection was carried out by:

Charlie Taylor	Chief inspector
Martin Kettle	Team leader
David Foot	Inspector
Martyn Griffiths	Inspector
Rebecca Mavin	Inspector
Chelsey Pattison	Inspector
Tamara Pattinson	Inspector
Kellie Reeve	Inspector
Fiona Shearlaw	Inspector
Charlotte Betts	Researcher
Rachel Duncan	Researcher
Grace Edwards	Researcher
Helen Ranns	Researcher
Maureen Jamieson	Lead health and social care inspector
Dawn Angwin	Health and social care inspector
Celia Osuagwa	Pharmacist inspector
Bev Gray	Care Quality Commission inspector
Montse Perez Parent	Ofsted inspector
Andrew Fitt	Ofsted inspector
Dave Baber	Ofsted inspector
Steve Lambert	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.

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).

Special purpose licence ROTL
Special purpose licence allows prisoners to respond to exceptional, personal circumstances, for example, for medical treatment and other criminal justice needs. Release is usually for a few hours.

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.

Appendix III Care Quality Commission Requirement Notice

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

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

Provider

Oxleas NHS Foundation Trust

Location

HMP Maidstone

Location ID

RPGAB

Regulated activities

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

Action we have told the provider to take

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

Regulation 12: Safe Care and Treatment 12 (1)(2.1,2.2a,b,e,f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

To meet this regulation: care and treatment must be provided in a safe way for service users. Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include – assessing the risks to

the health and safety of service users of receiving the care or treatment; doing all that is reasonably practicable to mitigate any such risks.

How the regulation was not being met

- We identified five patients who had been referred to secondary care for review and treatment which had not been chased or followed up by health care staff adequately, some of whom had significant and serious health needs. One patient required emergency review which had been processed only as an urgent referral.
- We identified one patient who required medical equipment to manage their health condition. This equipment had not been sourced and was needed in advance of undergoing a medical procedure.
- We identified that reception screening did not consistently identify or record patients' health concerns or family history.
- Translation services were not consistently used by healthcare staff when attending reception screening or other healthcare appointments.
- Healthcare staff did not always make referrals to the social care team when patient needs were identified either at reception screening or when attending other healthcare appointments.

To meet this regulation providers must have suitable systems in place to ensure patients receive safe care and treatment and that avoidable harm or risk of harm is prevented.

Regulation 17: Good Governance 17 1 and 2(a to e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

To meet this regulation: Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part. Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services); assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided; maintain securely such other records as are necessary to be kept in relation to persons employed in the carrying on of the regulated activity, and the management of the regulated activity.

How the regulation was not being met

- Arrangements to manage and monitor external hospital appointments were not adequate which meant that some patients referred on to secondary care had not been given appointments and this had not been adequately followed up by the provider.
- We found that a spreadsheet to monitor external hospital appointments had been established in July 2022, however, the spreadsheet failed to capture sufficient detail, including dates appointments had been chased

or responses received. We identified patients who had been referred for treatment before July 2022 who had not been included on the monitoring spreadsheet.

- The provider had not developed guidance to chase external hospital appointments including the frequency according to urgency or action to take should the hospital not respond to reminders.
- Staff were not following standard operating procedures to ensure that medicines were supplied and recorded safely.
- Medicines requiring storage at room temperature were not stored appropriately.
- The non-collection of in-possession medicine was not consistently recorded or followed up, so the use of medicines was optimised.
- There was insufficient oversight or leadership from a pharmacist.
- Pharmacist led clinics to provide medicines advice or medicine use reviews were not available.

To meet this regulation providers should have a suitable systemin place to ensure there are systems and processes in place which are operated effectively.

Appendix IV Further resources

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

Prison population profile

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

Prisoner survey methodology and results

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

Prison staff survey

Prison staff are invited to complete a staff survey. The results are published alongside the report on our website.

Crown copyright 2022

This publication, excluding logos, is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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

This publication is available for download at: http://www.justiceinspectorates.gov.uk/hmiprisons/

Printed and published by:
Her Majesty's Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England

All images copyright of HM Inspectorate of Prisons unless otherwise stated.