Report on an independent review of progress at

HMP Chelmsford

by HM Chief Inspector of Prisons

15–17 April 2019

This progress visit was carried out in partnership with the following body:

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

Printed and published by:
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Glossary of terms

We try to make our reports as clear as possible, but if you find terms that you do not know, please see the glossary in our 'Guide for writing inspection reports' on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

About this report

A1 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.

A2 All visits carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

A3 Independent reviews of progress (IRPs) are a new type of visit designed to improve accountability to Ministers about the progress prisons make towards achieving HM Inspectorate of Prisons' recommendations in between inspections. IRPs will take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny, and will focus on a limited number of the recommendations made at the inspection. IRPs will therefore not result in assessments against our healthy prison tests.[1]

A4 The aims of IRPs are to:

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

A5 This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each recommendation we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in May–June 2018, for further detail on the original findings.[2]

IRP methodology

A6 IRPs will be announced at least three months in advance and will take place eight to 12 months after the full inspection. When we announce an IRP, we will identify recommendations from the original inspection report which are of most importance to the well-being of prisoners (usually no more than 15) and communicate these to the Governor/Director of the prison.

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1 HM Inspectorate of Prisons' healthy prison tests are safety, respect, purposeful activity and rehabilitation and release planning. For more information see our website: https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/

2 Available at https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/10/HMP-Chelmsford-Web-2018.pdf

A7 During our three-day visit, we will collect a range of evidence about the progress in implementing each selected recommendation. Sources of evidence will include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

A8 We will make one of four possible judgements for each recommendation we follow up:

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

- **Insufficient progress**
  Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken had not yet resulted in any discernible evidence of progress (for example, better systems and processes) or improved outcomes for prisoners.

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

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

A9 Depending on the recommendations to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

Key findings

S1 At this IRP visit, we followed up nine of the 10 key recommendations made at our most recent inspection and made judgements about the degree of progress achieved to date.[3]

S2 We judged that there was good progress in one recommendation, reasonable progress in three recommendations and insufficient progress in five recommendations. A summary of the judgements is as follows.

Figure 1: Progress on recommendations from 2018 inspection (n=9)

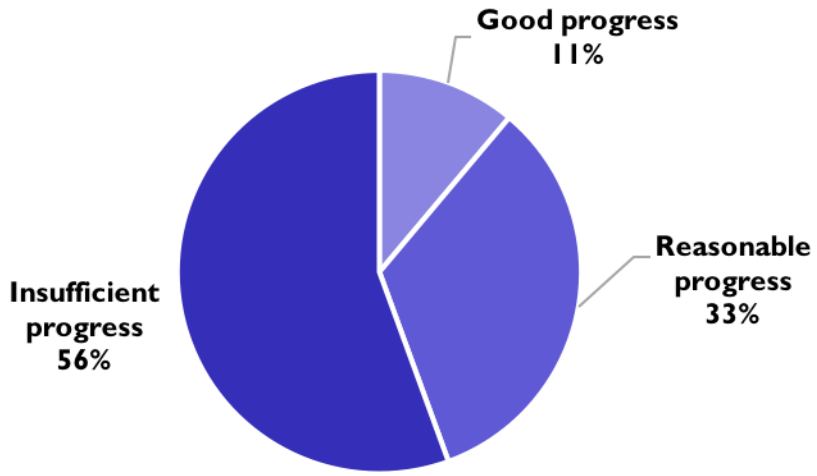


Figure 2: Judgements against individual recommendations from 2018 inspection

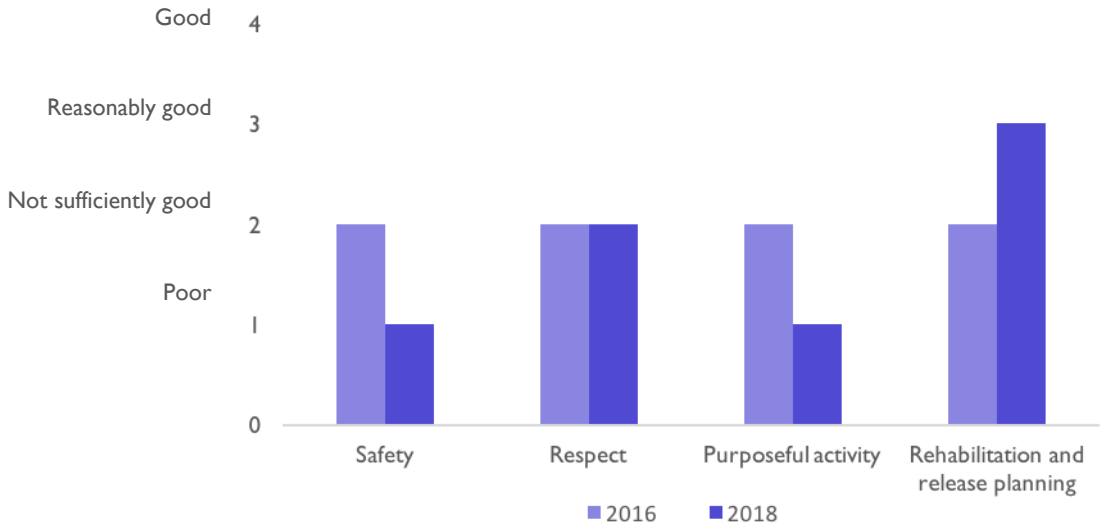
Recommendation	Judgement
Managers should work proactively to reduce levels of violence and develop and embed a range of initiatives to address the problem. (S38)	Reasonable progress
Managers should invest in staff, processes, resources and technology to help reduce the drug supply into the prison. (S39)	Insufficient progress
Managers should improve the care staff provide to men who were at risk of self-harm and there should be a better focus on the issues raised by the PPO in relation to deaths in custody. (S40)	Reasonable progress
Managers should ensure prisoners are held in clean and respectful living conditions. (S41)	Good progress
Managers should ensure there are clear and effective processes so prisoners can be consulted, make requests and resolve issues. (S42)	Insufficient progress
Robust governance structures, including consistent and competent health staff, effective leadership and improved partnership working between the prison and health providers, should ensure health provision consistently meets the needs of prisoners. (S43)	Reasonable progress
Time out of cell should be improved and adhere to the published regime. (S44)	Insufficient progress
Men should have at least an hour's exercise outside every day. (S44)	Insufficient progress
Managers should ensure that men have their resettlement needs assessed on arrival and prior to release, and that offender management arrangements meet the needs of all eligible groups. (S46)	Insufficient progress

[3] Ofsted is undertaking a separate monitoring visit to assess progress against the key themes identified in the learning and skills section of our 2018 inspection report, including one key recommendation in this area.

Section 1. Chief Inspector's summary

1.1 At our inspection of HMP Chelmsford in May–June 2018 we made the following judgements about outcomes for prisoners.

Figure 3: HMP Chelmsford healthy prison outcomes 2016 and 2018



1.2 HMP Chelmsford is a medium-sized local prison holding prisoners on remand and sentenced. It had an operational capacity of over 700 but at the time of this review visit the population had been reduced by about 60 to enable the refurbishments of some wings. However, this reduction was a temporary measure and we were told that HMPPS would increase the population in the very near future. As the prison was overcrowded even with the reduced population, we had major concerns about the return to the unacceptable overcrowding we saw last year and the inevitable impact of this, particularly on safety and decency.

1.3 The last full inspection was carried out in June 2018 and we had key concerns in many areas of our healthy prison tests, which had persisted and even deteriorated in some areas since the previous inspection in 2016.

1.4 We gave our lowest possible judgement on safety because of several major concerns. For example, the level of violence was very high and some was serious. There was a lack of insight into the causes of violence and little action taken to reduce it, despite a desire by staff to make improvements. Illicit drugs and other banned items were easy to obtain, and the mandatory drug testing (MDT) rate was one of the highest recorded in England and Wales. Prisoners at risk of self-harm were not managed well enough, and there had been a high number of self-inflicted deaths – 16 in the previous eight years.

1.5 The living conditions for prisoners were mixed, and there were unacceptable standards of cleanliness and lack of access to some very basic items. Prisoners were immensely frustrated at not being able to resolve even the simplest of problems or get answers to applications. Health care leadership needed improving and some important areas of the provision needed urgent attention.

1.6 Purposeful activity also received our lowest judgement. The lack of time out of cell, with many prisoners spending up to 22 hours a day locked up, was a major concern. Although Ofsted was unable to join us at this review visit, it will follow up its concerns about lack of

purposeful activity and other provision found in 2018 through a monitoring visit in the near future.

1.7 I did not issue an Urgent Notification in 2018 as I had confidence that the new governor would make progress on and strive to make the improvements we were seeking following that inspection.

1.8 At this independent review of progress we followed up nine main recommendations. We found good or reasonable progress in four of these, all relating to some of the key aspects of safety and respect that had concerned me last year. In the other five recommendations, we judged there to be insufficient progress.

1.9 Levels of violence had continued to increase since last year, but it was clear that action taken by the prison had led to a reduction in serious incidents. There was also better resourcing of the safer custody team and improved analysis of data with a clearer understanding of the causes of violence, alongside the introduction of a range of initiatives to tackle perpetrators and support victims. However, the availability of banned items and the use of illicit drugs continued to underpin much of the violence.

1.10 The number of deaths in custody through suicide and the suspected use of illicit drugs remained worrying, but there had been reasonable progress in improving the quality of care for prisoners in crisis or at risk of self-harm. However, the prison needed to keep recommendations from the Prisons and Probation Ombudsman (PPO) under constant review to ensure that progress was sustained.

1.11 The prison had made progress in improving living conditions. Major investment in refurbishments on some of the older wings had delivered much needed improvement to the conditions of many showers, toilets and cells. Prisoners now had better access to basic items, such as bedding and pillows, although the prison needed to do more to sustain this advance. The prison had dealt with most of the litter and rubbish we had seen previously in the external communal areas and cell window grilles.

1.12 There had also been reasonable progress in the provision of health care. The new provider commenced just two weeks before this review visit and had already begun to address many of our concerns.

1.13 I found insufficient progress in achieving the recommendations we made in the remaining five areas. The prison had taken some active steps to stem the flow of drugs and other illicit items into the prison, and this had resulted in a lower MDT rate and a reduction in the contraband thrown over the wall into the prison. However, it was inexcusable that HMPPS had still not equipped the prison with more up-to-date drug detection equipment. For this reason, I judged the progress made since our inspection to be insufficient. Chelmsford needed to make further reductions in the supply of drugs a priority to safeguard prisoners' health and well-being, as well as making the prison safer by reducing violence and debts.

1.14 Consultation with prisoners had improved but needed to be more widely publicised across the prison. The introduction of prisoner information desk (PID) workers was positive but the prison had not addressed the fundamental weaknesses in the application and complaints processes sufficiently well – some prisoners remained frustrated at their inability to gain answers to simple requests or queries.

1.15 Time out of cell, although more predictable across the prison, remained very limited, particularly in the evening and at weekends and for those not involved in purposeful activity. Despite the governor's aspiration to provide at least one hour a day for outdoor exercise, most prisoners still only had 30 minutes, which was not enough.

1.16 In rehabilitation and release planning, I had had concerns about the delivery of the community rehabilitation company (CRC)[4] contract, and some key weakness in offender management arrangements. The CRC provision through the crime reduction charity Nacro[5] had shown reasonable progress with clear signs of further advances under way. There had been little development in increasing offender supervisor contact with some prisoners, and the interdepartmental risk management team was not well defined and did not provide the oversight needed for high-risk prisoners being released into the community.

1.17 Last year, I clearly noted my confidence in the prison's capacity for change and improvement, and this was well-founded. The governor continued to set a clear vison for the prison and had retained the support of those around her. We have identified good or reasonable progress in four key areas, and this report makes clear what needs to be done to make advances in the remaining weak areas. While additional regional and national resources had been used to good effect, the lack of more sophisticated drug detection equipment was indefensible, and the easy availability of drugs continued to undermine other progress made.

Peter Clarke CVO OBE QPM April 2019
HM Chief Inspector of Prisons

4 Since May 2015 rehabilitation services, both in custody and after release, have been organised through CRCs which are responsible for work with medium- and low-risk offenders. The National Probation Service has maintained responsibility for high- and very high-risk offenders.

5 Formerly National Association for the Care and Rehabilitation of Offenders.

Section 2. Progress against the main concerns and recommendations

The following provides a brief description of our findings in relation to each recommendation followed up from the full inspection in 2018. The reference numbers at the end of each recommendation refer to the paragraph location in the full inspection report.

Managing behaviour

Concern: Levels of violence were very high and had been increasing since at least 2016. They were significantly higher than those we usually see in similar prisons. The strategic management of violence had been weak until recently, but had started to improve. However, investigations were not good enough and there was an over-reliance on disciplinary processes and the IEP [incentives and earned privileges] scheme to manage poor behaviour. The reasons for poor behaviour were not understood and the prison did not work sufficiently with perpetrators.

Recommendation: Managers should work proactively to reduce levels of violence and develop and embed a range of initiatives to address the problem. (S38)

2.1 Reported violence had continued to increase since our inspection in 2018 and remained much higher than we find in similar prisons. However, the number of serious assaults had reduced by over 50%, which was evidence of the improvement starting to be made.

2.2 There had been reasonable progress in addressing violence, supported by additional national and regional resources. The safer custody department was better resourced and stable, but had suffered from cross-deployment of some staff to operational duties. There had been advances in understanding the reasons for violence, and improving data collation and analysis. This included the use of a priority rating system for all incidents of violence, better use of national prison data systems and improved consultation with prisoners on a broad range of violence-related issues.

2.3 The range of interventions to manage violence and other antisocial behaviour had improved. They included courses aimed at managing stress and anxiety, and some simple practical steps to help prisoners avoid getting into debt. The introduction of D wing as a 'reintegration' unit for those leaving segregation was showing some early signs of progress, and there was more focus on educating and skilling staff in the management of prisoners with complex behaviour.

2.4 Since our inspection in 2018, the 'challenge, support and intervention plan' (CSIP)[6] case management process had been fully introduced. Investigations were now undertaken reasonably promptly, and there was a triage system to address the small number of outstanding cases. Investigations were of an adequate quality, but individual management plans lacked sufficient detail and did not use the full range of interventions available.

2.5 Support for prisoners who were self-isolating and those with vulnerabilities relating to debt and bullying had improved. Relationships between the safer custody team and other prison departments were now reasonably effective, and there was evidence of some collaborative

[6] Used by some prisons to manage the most violent prisoners and support the most vulnerable prisoners in the system. Prisoners identified as the perpetrator of serious or repeated violence, or who are vulnerable due to being the victim of violence or bullying behaviour, are managed and supported on a plan with individualised targets and regular reviews.

work with the mental health team and psychology services in the management of cases presenting the most complex problems.

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

Security

Concern: Survey results, finds and positive test results all indicated that drugs were easily available. Over 40% of all prisoners said it was easy to obtain illegal drugs and the positive drug testing rate of 42.6% (combined random and synthetic cannabinoids) was among the highest in England and Wales according to HMPPS data. The prison held a large number of men connected to organised crime gangs, who were responsible for much of the supply of illicit items, including drugs and mobile phones. Managers had taken sensible steps to address these threats, but they were not enough – the perimeter remained very vulnerable and it seemed that the drug supply was fuelling levels of violence.

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

2.7 The prison had taken a range of active steps to reduce the availability of drugs and other prohibited items. There was no backlog of incident reports. Physical security had been improved with additional netting over one exercise yard, and some of the most damaged window grilles had been replaced. A combination of improved analysis, increased internal patrols and improved joint working with the local police and community had considerably reduced the items thrown over the prison wall. The positive drug testing rate (combined random and synthetic cannabinoids) remained high at 36.8% but this was lower than the 42.6% recorded at our inspection last year, supporting evidence of the progress made.

2.8 Improved identification of prominent and active organised crime gang members was allowing for more targeted management and disruption tactics. The prison now completed a large proportion of intelligence-led cell searches. Corruption prevention processes were robust, and had led to some notable finds and evidence of illegal activity by some staff. Security processes in visits had been tightened with more prisoners searched before their visit, x-rays of visitor footwear and some targeted joint operations with the police. However, very few suspicion drug tests were completed.

2.9 Further progress over the last 10 months had been hindered by the failure of HMPPS to provide the prison with a full body scanner to help stem the flow of drugs and other illicit items into the prison. There had been no funds to buy a relatively inexpensive itemiser[7] to detect drugs coming in through the mail or other items, and an x-ray machine had been broken for several months. Furthermore, although there was now additional netting over one of the exercise yards, this had taken several months to be installed. The lack of priority to providing up-to-date drug detection equipment was the main reason for our following judgement.

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

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[7] A scanning machine used to detect illicit substances impregnated on items of post.

Safeguarding

Concern: Levels of self-harm were very high. There had been 16 self-inflicted deaths in the previous eight years, four in the two years since we last visited. The response to these trends had been inadequate. The prevention of suicide and self-harm had not been prioritised sufficiently and the safer custody team had no strategy or action plan to reduce levels of self-harm. Some deficiencies repeatedly highlighted by the PPO had not been addressed. ACCT[8] documents were not good enough and the number was unmanageable. Staff lacked the experience and confidence to support men most in crisis and insufficient Listeners[9] were in place. The level of constant supervision was unmanageably high and arrangements were unsafe. Cell emergency bells often went unanswered for considerable periods of time.

Recommendation: Managers should improve the care staff provide to men who were at risk of self-harm and there should be a better focus on the issues raised by the PPO in relation to deaths in custody. (S40)

2.11 Although the levels of self-harm remained high and similar to those found at our inspection in 2018, there had been good progress in improving the quality of care provided to those at risk. There had been a high priority on training staff to be more confident in their care of prisoners in crisis – 99% of staff had received some modules of the ACCT training and 88% had completed all the ACCT training.

2.12 The quality of ACCT casework management documentation had improved since the inspection and was now good. All ACCTs we reviewed had a comprehensive care map, most entries were of a good quality and staff adhered to the agreed observation levels. Mental health or health care staff attended all ACCT reviews, which was positive. Managers were involved in the quality assurance process, and all concerns were also escalated to the safer custody department. Not all ACCTs had a named case manager and more work was needed to address this.

2.13 Although Listener provision had increased slightly to nine from seven in 2018, there was still only one Listener on the first night centre. Prisoners could now telephone the Samaritans helpline free of charge from their in-cell telephones, which was positive.

2.14 There had been two self-inflicted deaths since our inspection and a further three deaths thought to be linked to illicit drug use. PPO recommendations relating to health care were monitored well, and there had been good progress in this area. Although PPO recommendations were a standing agenda item on the monthly safer custody and violence reduction meeting, and included in the monthly safer custody report, not all the recommendations were actively reviewed to ensure that progress was made or sustained.

2.15 The safety intervention meeting, which helped support prisoners with more complex needs, lacked senior management attendance, which undermined its purpose and effectiveness.

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

8 Assessment, care in custody and teamwork case management documents for prisoners at risk of suicide or self-harm.
9 Prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners.

Living conditions

Concern: The prison was overcrowded. Some areas of the prison were dirty, graffiti was widespread and many cells had broken or missing furniture and unscreened toilets without lids. The offensive displays policy was not being adhered to. Many maintenance tasks were outstanding, which exacerbated prisoners' poor conditions. There was a shortage of some key amenities, including pillows, mattresses, sheets and kettles.

Recommendation: Managers should ensure prisoners are held in clean and respectful living conditions. (S41)

2.17 Although at this review visit the prison's operational capacity had reduced and there were 66 fewer prisoners than in 2018, Chelmsford remained overcrowded, with 23% of prisoners still sharing cells that were originally designed for one. The temporary reduction in the population had helped the management of the refurbishment programme put in place following the 2018 inspection. However, the population was due to increase again following completion of the refurbishment, which would once again undermine the prison's efforts to provide safe and decent living conditions.

2.18 Outside areas were much cleaner, with less rubbish than at our 2018 inspection. There had been major improvements to living conditions on some of the older wings. Two landings on C wing had received a complete refurbishment, including new flooring in cells and communal areas. In cells, new furniture had been installed, and toilets and sinks had been deep cleaned. New communal showers had been installed on B and C wings and in the segregation unit. The serveries on A and D wings had been refurbished, and a new laundry installed on D wing. All of these improvements represented good progress. (See Appendix II: Photographs.)

2.19 A cell painting programme was in place with regular checks in cells for graffiti. There were now better compliance checks of cell conditions and daily cleaning schedules. A new offensive display policy had been introduced in January 2019 and wing staff had received refresher training in how to enforce it.

2.20 Prisoner access to amenities had improved, and all cells we inspected had a pillow, mattress, clean bedding and a kettle. A new kit change process had been introduced in January 2019, but there were still some outstanding issues with its implementation.

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

Prisoner consultation, applications and redress

Concern: Prisoners were frustrated by their inability to get basic queries or requests dealt with. Consultation arrangements were underdeveloped, the application process did not work effectively and complaints were poorly managed.

Recommendation: Managers should ensure there are clear and effective processes so prisoners can be consulted, make requests and resolve issues. (S42)

2.22 Following our inspection in 2018, there had been progress in some of our areas of concern. For example, a PID worker scheme had been introduced and there were now seven prisoners trained to support others by addressing queries on the residential units. However, there needed to be further management supervision and oversight of their work, and clarification of their role.

2.23 Formal consultation with prisoners had improved through the reintroduction of the prisoner council. This was well attended by staff and prisoners, and chaired by the governor or another senior member of staff. However, it required better promotion and publicity as many prisoners we spoke to were unaware of it. Information from the meetings was not yet shared routinely with the whole prison to ensure maximum inclusion in consultation.

2.24 Prisoners we spoke to were still negative about the applications process. Although PID workers now issued, collected and logged applications submitted, there was still no systematic monitoring of the quality or timeliness of responses.

2.25 The number of complaints in the previous six months was similar to our 2018 inspection. Complaints data were collected and trends identified in monthly reports to the senior management team meeting. Despite this, there had been an increase in the number of late responses, from 20% last year to 37% at this review visit. There was no routine quality assurance of responses, and complaint forms were not readily available on all residential units during our review visit.

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

Health, well-being and social care

Concern: Some important aspects of health provision were poor, including incident reviews and complaints management, exacerbated by health staffing shortages. Many prisoners waited too long for primary care services and mental health provision did not meet the population's needs. Some aspects of medications management were unsafe and pre-release planning for primary and mental health services was poor. Partnership working between health and prison managers needed to be stronger to drive improvements.

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

2.27 The new health provider, Castle Rock Group Medical Services (CRG), had taken over the contract on 1 April 2019. Positive partnership working between the new provider and the prison was evident, with several examples of proactive joint strategic and operational work. There was now strong leadership, and the new senior health team was visible to patients and accessible to health and prison staff.

2.28 CRG was making progress towards establishing systems to manage complaints and incidents. There was a separate confidential health care complaints system.

2.29 Staffing levels were under review, but safe levels were maintained by use of agency staff, staff who had transferred to CRG and an active recruitment campaign, which had resulted in a conscientious staff group.

2.30 Some key aspects of the provision had developed well in a very short time. For example, the health application appointment process had been revised and the high failure-to-attend rate had since decreased. Waiting times for primary care services had reduced and were now within acceptable timescales.

2.31 There was effective oversight and more robust measures to ensure medicines were stored safely, including systematic monitoring of fridge and room temperatures.

2.32 There was a clear pathway for patients needing mental health support. Staff effectively reviewed patient risks and documented treatment needs. Patient-centred care plans were completed, and copies were given to them. Patients needing lower level psychological interventions could access this through the improving access to psychological therapies (IAPT) team and counselling services.

2.33 Health care release planning had improved. A nurse saw all prisoners before their release, and a discharge summary was sent to their GP. All patients identified under the care programme approach were offered the required support, which helped release planning and community treatment goals.

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

Time out of cell

Concern: The maximum time out of cell available was just over seven hours, but most men had much less than this. Most men were not engaged in activities and usually spent just two hours a day out of their cells. There were also often very long periods between unlocking. In this context, outside exercise was particularly important, and exercise periods took place regularly, [but] they were too short.

Recommendation: Time out of cell should be improved and adhere to the published regime. (S44)

2.35 At our 2018 inspection we found 35% of prisoners locked in their cells during the core working day, which was far too high. On this visit, the proportion locked in their cell during the working day had reduced slightly to 27%, but this was still too high.

2.36 Although the core day had been reviewed, association and exercise time remained poor for most prisoners – for example, they amounted to only two hours a day at the weekend, which meant prisoners were still locked up for 22 hours a day. Time out of cell was better for prisoners living on G wing, which held a mix of enhanced prisoners and those who were vulnerable due to the nature of their offence. The prison had planned a further review to make progress on improving evening and weekend provision for all.

2.37 The new core day had been published on all the wings and was largely adhered to, which gave prisoners the continuity we found lacking at our inspection last year. The reliability of time out of cell for basic-level prisoners had improved and this was now included in the published regime.

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

Recommendation: Men should have at least an hour's exercise outside every day. (S44)

2.39 HMPPS had rejected this recommendation as our expectation of one hour a day exercise outside is not in line with the Prison Service instruction setting out just 30 minutes a day. We continue to review the arrangements in line with our expectations.

2.40 The prison governor and her team recognised the need to take this issue seriously and had revised the schedule for the core day to include one hour of exercise in the open air. However, at the time of our visit this was not being achieved and most prisoners only had 30 minutes a day to go outside.

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

Rehabilitation and release planning

Concern: The rehabilitation needs of many men were not assessed on arrival and in some cases, staff were not proactive enough about meeting them. Offender management support for low and medium risk men was underdeveloped and meaningful contact limited. Referral processes and information sharing across agencies and departments were not sufficient to ensure men received the support they needed to progress to other prisons and on release.

Recommendation: Managers should ensure that men have their resettlement needs assessed on arrival and prior to release, and that offender management arrangements meet the needs of all eligible groups. (S46)

2.42 At our inspection in 2018, we found that almost half of the basic custody screening tool assessments had not been completed on prisoners' arrival. Improvement had been made in the last 10 months; on this visit we found that 84% of prisoners had been screened on arrival and only 3% did not have a resettlement plan.

2.43 To date, there had been insufficient progress in reviewing prisoners' resettlement plans in preparation for their release. However, Nacro (the provider subcontracted by the CRC) had recently doubled its staff numbers, which would help ensure that all plans are reviewed in preparation for release.

2.44 There were strengthened strategic partnerships between the CRC, the prison and the offender management unit. Resettlement pathway action plans were now in place and reviewed regularly, and showed ongoing improvement. There had been advances to support joint working for frontline staff through mutual training and promoting the sharing of information, which were showing signs of improvement.

2.45 Some of our concerns about the quality of offender management remained. There had been little improvement in the contact levels between uniformed offender supervisors and prisoners on their caseload. This was caused by the ongoing cross-deployment of uniformed offender supervisors to operational duties across the prison. In addition, the key worker scheme, which should have helped weekly contact, was not effective with only 15% of its projected hours delivered over recent months.

2.46 At our 2018 inspection, we were concerned that the inter-departmental risk management team (IRMT) was not effective, and this remained the case. Although there had been attempts to develop the IRMT, it did not have a high enough priority across the prison, its role was confused and it did not routinely make plans or provide oversight for the release of prisoners presenting a high risk of harm in the community. There was no clear multi-agency public protection arrangements (MAPPA) management level agreed for a quarter of all prisoners due for release in the next three months who were subject to MAPPA (11 out of 44 cases), which suggested that joint planning with the community-based offender manager was still not active enough.

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

Section 3. Appendices

Appendix I: Review team

Peter Clarke	Chief inspector
Sandra Fieldhouse	Team leader
Fionnuala Gordon	Inspector
Keith Humphreys	Inspector
Kam Sarai	Inspector
Emma Sunley	Inspector
Caroline Wright	Inspector
Maureen Jamieson	Health and social care inspector
Lynda Day	Care Quality Commission inspector

Appendix II: Photographs

B wing in 2018

B wing during the IRP visit

Segregation exercise yard in 2018

Segregation exercise yard during the IRP visit

Segregation exercise yard in 2018

Segregation exercise yard during the IRP visit

Example of a communal shower in 2018

Communal showers during the IRP visit

Renovated C wing during the IRP visit