Report on an independent review of progress at

HMP Durham

by HM Chief Inspector of Prisons

1 – 3 July 2019

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

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 September and October 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 which recommendations we intend to follow up (usually no more than 15). Depending on the recommendations to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

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.

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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 The report of the 2018 inspection can be found at: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-durham-3/

A8 Each recommendation followed up by HMI Prisons during an IRP will be given one of four progress judgements:

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

- **Insufficient progress**
  Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken 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 When Ofsted attends an IRP its methodology will replicate the monitoring visits conducted in further education and skills provision. Each theme followed up by Ofsted will be given one of three progress judgements.

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

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

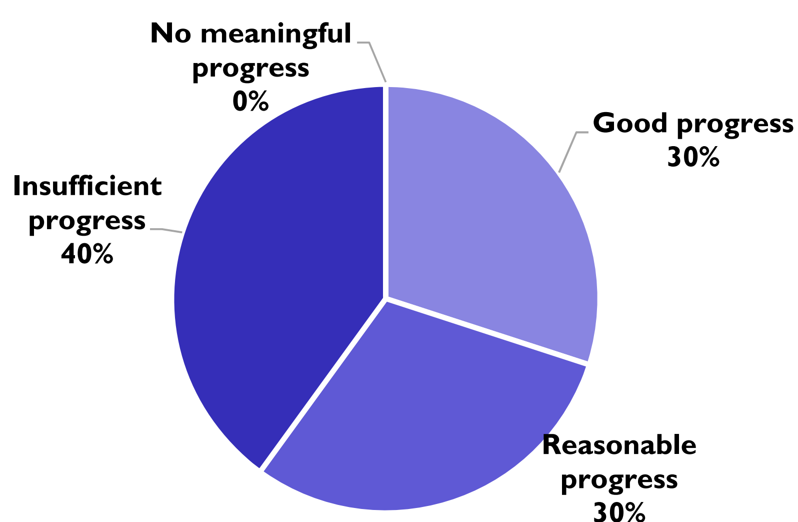
- **Significant progress**
  Progress has been rapid and is already having considerable beneficial impact on learners.

Key findings

S1 At this IRP visit, we followed up 10 of the 54 recommendations made at our most recent inspection and made judgements about the degree of progress achieved to date. Ofsted followed up three themes.

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

Figure 1: Progress on recommendations from 2019 inspection (n=10) [3]



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

Figure 2: Judgements against HMI Prisons' recommendations from October 2018 inspection

Recommendation	Judgement
Reception and first night processes should include a thorough assessment of prisoners' immediate vulnerabilities, needs and risks through a private interview with custodial staff to ensure appropriate support is offered. (S43)	Reasonable progress
Additional night time checks should be undertaken for all new arrivals. (S43)	Good progress
The casework approach to managing and changing poor behaviour and assisting vulnerable prisoners through support and intervention plans should be embedded in practice. (1.18)	Reasonable progress
Safety should be improved by reducing the supply of illicit drugs. This should include the introduction and use of more sophisticated drug detection equipment. (S44)	Good progress
The management of prisoners at risk of suicide or self-harm should be given a high priority. There should be a comprehensive action plan, covering PPO recommendations, that is regularly reviewed to ensure they continue to be implemented effectively. ACCTs should be consistently good and ensure that individual prisoners receive appropriate care and support. (S45)	Insufficient progress
The prison should have a coherent strategy to reduce self-harm, informed by the specific characteristics of the population at HMP Durham. It should include a meaningful analysis of data and an action plan. (1.50)	Reasonable progress
Staff's interactions with prisoners should be monitored and feedback should be offered to ensure they respond confidently and immediately to poor behaviour. (2.4)	Good progress
Offender management of prisoners presenting high risk of harm to others should be improved and should include adequate training for offender supervisors. High risk cases due for release should receive better management oversight from within the prison, and release planning with the community-based offender manager should be consistently good. (S46)	Insufficient progress
MAPPA management levels should be confirmed with the community-based offender manager at least six months to release. (4.25)	Insufficient progress
The IDRMT should review all high and very high risk of harm cases prior to release to ensure appropriate action and restrictions are in place. (4.26)	Insufficient progress

S3 Ofsted judged that there was reasonable progress in two themes and insufficient progress in one theme.

Figure 3: Judgements against Ofsted themes[4] from October 2018 inspection

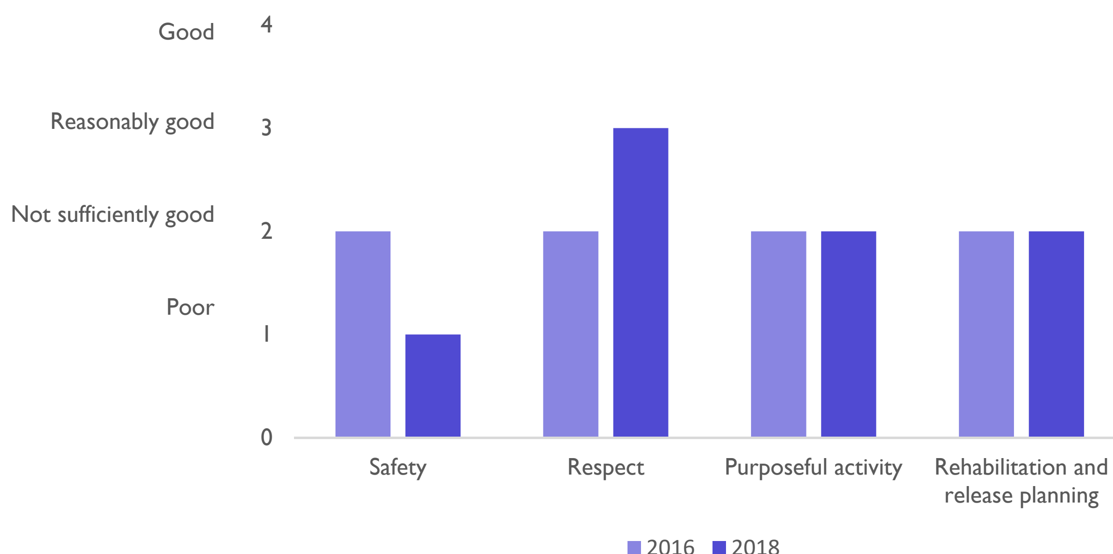
Ofsted theme	Judgement
What progress have leaders and managers made with their strategies to ensure that they have the appropriate oversight of the quality of teaching, learning and assessment throughout activities, improving the provision for vulnerable prisoners and enabling them to measure the progress that learners make, including in their standards of work?	Reasonable progress
What progress have leaders and managers made in improving the quality of teaching, learning and assessment through monitoring and ensuring that tutors accurately identify learners' starting points and use this information to plan learning for all learners effectively, setting up challenging targets for learners, and towards the development of their English and mathematics skills across all activities?	Reasonable progress
What progress have leaders and managers made in improving the reliability of the data they use to enable them to track the quality of prisoners' progress when they transfer to other prisons and to monitor achievements by prisoners ensuring that achievement rates in English improve?	Insufficient progress

4 Ofsted's themes incorporate the key concerns at the previous inspection in respect of education, skills and work.

Section 1. Chief Inspector's summary

1.1 At our inspection of HMP Durham in 2018 we made the following judgements about outcomes for prisoners.

Figure 4: HMP Durham healthy prison outcomes 2016 and 2018.



1.2 HMP Durham dates from the early 19th century and is located close to the centre of the city. It had, since May 2017, been designated as a reception prison, taking large numbers of new receptions from a huge geographical area across the North-east and Cumbria, resulting in well over 100 receptions a week. The majority of prisoners were on remand, recalled or serving very short sentences which presented challenges similar to local prisons, including significant pressure on reception and work undertaken in the first few days of custody.

1.3 At our last inspection in October 2018, we judged that outcomes for prisoners in relation to safety at HMP Durham were poor. There was a very high prevalence of illicit drug use. The prison was well aware of the dangers posed by drugs but was immensely frustrated by the fact that no modern technology was available to it to help stem the flow of drugs into the prison. Several prisoners had committed suicide while at Durham in the two years before our inspection in 2018, but in addition to this there had been five suspected drug related deaths in eight months. Despite this high number of deaths, the prison's response to the Prisons and Probation Ombudsman (PPO) recommendations had been weak. Levels of violence had increased over the two years, some incidents were serious and much violence centred on illicit drug use and associated debts. Although staff-prisoner relationships were positive overall, a large number of new staff had been recruited, some of whom lacked the confidence to manage prisoners' poor behaviour.

1.4 Ofsted judged that the overall effectiveness of education, skills and work required improvement. Mechanisms had been developed for recording prisoners' progress but had not been implemented in some areas. There was too little use of quality assurance to improve practice and data to demonstrate effectiveness were not yet reliable.

1.5 The lack of good quality offender management was a significant concern, particularly for some prisoners who were due for release and presented a high risk of harm to others.

1.6 We concluded that the most pressing needs were to get to grips with violence of all kinds, reduce the flow of drugs and improve safety in the prison.

1.7 At this independent review of progress, HMI Prisons followed up 10 recommendations and Ofsted followed up three themes during their visit the week before the HMIP review. Ofsted and HMIP found good or reasonable progress in eight areas and insufficient progress in five.

1.8 Reasonable progress had been made in improving the initial safety checks undertaken on new prisoners with a revised assessment procedure. However, given the very large number of prisoners going through reception each day, it was often difficult for staff to complete these checks thoroughly. The very recent introduction of checks on new prisoners throughout the first night was a positive step, but prisoners returning from court whose circumstances had changed should have been included in the revised safety checks and interviews.

1.9 The prison's data showed that the levels of violence reported at this review were similar to the 2018 inspection, but the proportion of serious incidents had reduced which was positive. The challenge, support and intervention plan was now embedded and was being used more effectively to manage violent prisoners. However, a formal case management system was needed to support victims of violence, intimidation or bullying.

1.10 Good progress had been made in stemming the supply of illicit drugs. A body scanner was proving effective in deterring drug supply and finding illicit items. Many other steps had been taken or were in progress to reduce the supply of drugs, which was promising. Staff and prisoners whom we spoke to said the prison felt safer and our experience reflected this as we walked round the wings.

1.11 Three prisoners had committed suicide in the last nine months and attention to reviewing the implementation of PPO recommendations from previous reports was still insufficient. Despite efforts to improve the quality of ACCTs[5], procedures were not yet delivered well enough to provide effective care. More multidisciplinary planning and working were required to safeguard prisoners in crisis who had complex personal needs or were repeatedly self-harming. Reasonable progress had been made in establishing a more meaningful safety strategy which included improved analysis of self-harm data.

1.12 Positive relationships between staff and prisoners remained. Staff were better able to establish appropriate boundaries and challenge poor behaviour and the daily regime facilitated better control and supervision of prisoners during association.

1.13 Managers and leaders now gave appropriate oversight of the quality of education, skills and work, including identification of areas for improvement. However, managers did not have an accurate understanding of the progress made by individuals or groups of prisoners towards the achievement of their targets.

1.14 Not enough progress had been made with the three rehabilitation and release planning recommendations. Some improvements had been made to the allocation of cases, staff training and support, but the quality of offender management in the cases that we reviewed remained weak. This was particularly concerning in the high-risk cases where we found no recorded evidence of release planning with the community offender manager. Despite efforts to make the interdepartmental risk management team more effective, it still did not provide adequate oversight of all high risk of harm and MAPPA (multi-agency public protection arrangements) cases being released.

1.15 Overall, the outcomes of this independent review were positive. Senior managers had taken the recommendations from our last inspection seriously. Evidence suggested that the prison

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[5] Assessment, care in custody and teamwork case management of prisoners at risk of suicide or self-harm.

was becoming safer. Making it more difficult for drugs and other illicit items to enter the prison was having the desired effect and the prison was now better controlled and supervised. However, weaknesses in the suicide and self-harm prevention measures remained a significant concern and required urgent attention. Durham needed to give priority to improving the quality of risk management planning if we are to be confident that the public are protected when prisoners presenting a risk of serious harm are released.

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

Section 2. Progress against the key concerns and recommendations and Ofsted themes

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

Safety

Concern: The prison did not focus sufficiently on identifying prisoners' immediate vulnerabilities, needs or risks during the reception and first night process. Staff did not routinely undertake additional overnight checks on new arrivals on the first night wing.

Recommendation: Reception and first night processes should include a thorough assessment of prisoners' immediate vulnerabilities, needs and risks through a private interview with custodial staff to ensure appropriate support is offered. (S43)

2.1 The framework and system for the initial vulnerability assessment had been reviewed and a more comprehensive approach had been introduced. The first part of the assessment, which focused on vulnerability, was conducted in reception in a private room, an improvement since the 2018 inspection. This was followed by a private interview carried out by a member of the nursing staff. It was evident from talking to staff and observing these interviews that staff were working under considerable pressure because of the sheer volume of individuals who needed to be seen, and the process was often rushed. Mental health staff and prisoner orderlies were available every day in reception to provide immediate help and support, which was good.

2.2 A further private interview was undertaken on the first night unit which focused on ensuring that immediate welfare needs were met, such as maintaining contact with family members. This was supplemented by well organised, practical advice and support from prisoner information desk workers.

2.3 Prisoners returning from court were not formally risk assessed under the new system despite the fact that their circumstances had changed significantly in some cases. We observed two prisoners who had just received lengthy custodial sentences who could have benefited from the new procedures.

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

Recommendation: Additional night time checks should be undertaken for all new arrivals. (S43)

2.5 Additional checks during a prisoner's first night had been introduced the week before this review visit and advice had been issued to staff on how to carry out the procedure. A record of the checks was maintained on the first night unit.

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

Managing behaviour

Concern: A casework approach to managing and changing poor behaviour and helping vulnerable prisoners through challenge, support and intervention plans (CSIPs) had been introduced but was not embedded in practice. Referrals for CSIPs were made through the safer custody team following an investigation into a violent incident. However, many officers and some managers did not know about the CSIP procedure and staff relied too much on the safer custody team to manage operational matters relating to violence and to investigate incidents.

Recommendation: The casework approach to managing and changing poor behaviour and assisting vulnerable prisoners through support and intervention plans should be embedded in practice. (1.18)

2.7 The awareness and use of CSIPs for the management of perpetrators of violence or bullying had improved since our inspection. There had been 323 referrals to CSIPs in the last six months and 17 plans were open at the time of this review. The referral following an incident was sent to the safer custody administration staff who allocated referrals to custodial managers to investigate. There were limited staff in the safer custody department and allocation was sometimes delayed.

2.8 The quality of CSIPs was reasonable, intervention plans contained actions relevant to the prisoner's needs and regular reviews were completed. However, reviews were not always multidisciplinary or completed on time.

2.9 The weekly safety intervention meeting provided good oversight of the management of perpetrators of violence. All live CSIPs and new referrals were discussed with contributions from a range of departments which enhanced the multidisciplinary approach.

2.10 There was no formal multidisciplinary case management system and formal planning and support were too limited for vulnerable prisoners who were victims of violence, abuse or bullying.

2.11 We considered that the prison had made reasonable progress in this area.

Security

Concern: Safety was significantly undermined by the widespread availability of illicit substances. Much of the violence and other problems within the prison were linked to drug use and nearly a third of prisoners said they had developed a drug problem since being at the prison. Efforts to reduce the supply of drugs were hindered by the lack of sophisticated drug detection tools.

Recommendation: Safety should be improved by reducing the supply of illicit drugs. This should include the introduction and use of more sophisticated drug detection equipment. (S44)

2.12 The focus on improving safety by stemming the flow of illicit substances into the prison had been given a higher priority and a wide range of actions had been taken. A body scanner and detector poles were proving an effective deterrent in reducing the supply.

2.13 Additional security equipment had been installed including netting over exercise yards and additional cameras. A biometrics recognition system for visitors would represent significant progress if funding could be secured.

2.14 Mandatory drug test results showed that the use of psychoactive substances had declined since our inspection in 2018. However, the illicit use of prescribed medication had increased. Appropriate steps had been taken to manage this, including increasing staff supervision during the dispensing of prescribed medication.

2.15 Although levels of violence remained similar to 2018, the number of serious assaults had reduced. Prisoners and staff whom we spoke to said they felt safer than they had at the time of our inspection and our experience reflected this as we walked round the wings.

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

Safeguarding

Concern: There had been seven self-inflicted deaths since our last inspection and five suspected drug-related deaths over the previous eight months. The prison did not focus sufficiently on implementing PPO recommendations and ACCT case management was far too poor in many of the cases we reviewed.

Recommendation: The management of prisoners at risk of suicide or self-harm should be given a high priority. There should be a comprehensive action plan covering PPO recommendations that is regularly reviewed to ensure they continue to be implemented effectively. ACCTs should be consistently good and ensure that individual prisoners receive appropriate care and support. (S45)

2.17 There had been three self-inflicted deaths since our inspection which was a concern. The implementation of PPO recommendations from previous investigations into deaths at Durham had not been given sufficient priority. Until very recently, the review and monitoring of outstanding PPO recommendations had been unreliable and recommendations had gone unchecked for a long time.

2.18 There had been 356 acts of self-harm in the previous six months, almost exactly the same figure as at the 2018 inspection. The quality of ACCT case management records remained poor in spite of efforts to improve it. In the ACCTs that we reviewed, the level of risk of self-harm was sometimes underestimated, which was concerning, observations were not always recorded as completed on time and some care maps were weak. Some ACCTs were closed before the outcomes of actions had demonstrated a reduction in risk.

2.19 Prisoners who had been on ACCTs spoke to us positively of their experience and the ACCT review that we observed was conducted sensitively.

2.20 The management of prisoners with more complex needs, including those who repeatedly self-harmed, needed more attention than just a reliance on the ACCT process. A senior level, multi-departmental risk management meeting should provide expert advice, allocate additional resources and support the ACCT case manager in their work.

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

Concern: The strategic approach to reducing self-harm required improvement. Monitoring and analysis were underdeveloped. Data were collated and produced for the safer custody meeting, but the minutes did not reflect any discussion. The establishment did not give enough consideration to the unique factors at Durham that might have caused an increase in self-harm, such as the high prevalence of drugs, problems during prisoners' early days at the prison and the large number of prisoners with mental health problems.

Recommendation: The prison should have a coherent strategy to reduce self-harm, informed by the specific characteristics of the population at HMP Durham. It should include a meaningful analysis of data and an action plan. (1.50)

2.22 The safety policy was now informed by relevant factors at Durham such as the very high volume of admissions and the high level of violence and drug misuse.

2.23 There was now an action plan which was reviewed and monitored at the monthly safer custody meeting. Much of the plan related to operational matters which were addressed reasonably efficiently. However, the plan failed to address longer term strategic issues related to the role of Durham as a reception prison. One key area which needed close examination was the ability of staff in reception and early days roles to cope with the exceptionally high volume of new admissions while trying to undertake good quality risk assessments to safeguard those at risk of self-harm or suicide.

2.24 The quality of data analysis had improved. Monthly updates were presented to the safer custody meeting, including clear information about the frequency, location and type of self-harm incidents. More recently, profiles of the most prolific self-harmers had also been produced. The availability of good quality data led to more informed decisions, for example restrictions had recently been introduced on the issue of razors following increased prevalence in their misuse.

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

Staff-prisoner relationships

Concern: In general, we saw staff engaging courteously and constructively with prisoners on the wing. However, officers did not always challenge unacceptable behaviour, such as when prisoners were rude to other staff. On other occasions staff spoke to prisoners abruptly or even rudely.

Recommendation: Staff interactions with prisoners should be monitored and feedback should be offered to ensure they respond confidently and immediately to poor behaviour. (2.4)

2.26 We found that the management of prisoners on the wings had improved, largely because the regime limited the number of prisoners on association at any one time. This protected prisoners and enabled staff to supervise, manage and support prisoners in their care. We observed good staff supervision of prisoners and found a far more settled atmosphere on the wings which promoted positive working relationships. We also saw staff challenging poor behaviour by prisoners and enforcing the rules appropriately.

2.27 There was some evidence of improved monitoring of staff interactions with prisoners. For example, senior managers undertook monthly checks on the wings and there was more consistent deployment of supervising officers to each wing who could get to know staff and support them accordingly. The use of body-worn cameras during incidents had been promoted and staff were given feedback on their conduct during incidents.

2.28 Keyworkers had been allocated to each wing. Most prisoners we spoke to knew who their key worker was and spoke positively about them. The interactions that we observed were supportive and the frequency of keyworker entries on P-Nomis was good in the cases that we checked.

2.29 We considered that the prison had made good progress in this area.

Education, skills and work[6]

Theme 1: What progress have leaders and managers made with their strategies to ensure that they have appropriate oversight of the quality of teaching, learning and assessment throughout activities, improving the provision for vulnerable prisoners and enabling them to measure the progress that learners make, including in their standards of work?

2.30 At this visit Ofsted found that leaders and managers had established appropriate oversight of the quality of the provision. Information from lesson and activity observations, a good proportion of which managers carried out jointly with the education provider, enabled them to identify areas for improvement and appropriate staff development with a focus on improving teaching.

2.31 Managers had ensured that tutors and instructors embraced the academy-based curriculum intended to promote prisoners' development of five key employability skills and ultimately their engagement in activities. Tutors regularly reviewed and evaluated the progress that prisoners made towards the achievement of their personal targets and encouraged prisoners to make reflections on their skill development.

2.32 Prisoners in work settings demonstrated effective work-related skills, such as timekeeping and team work. Most were keen to be involved and engaged well with the development of their employability skills and completion of their employability portfolios.

2.33 At the previous inspection the provision for vulnerable prisoners was too limited. While the provision had not been significantly increased at the time of our visit, managers had invested in equipment and workshop space to ensure that vulnerable prisoners had access to a broader range of construction skills in bricklaying, joinery and painting and decorating.

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

Theme 2: What progress have leaders and managers made in improving the quality of teaching, learning and assessment through monitoring and ensuring that tutors accurately identify learners' starting points and use this information to plan learning for all learners effectively, setting up challenging targets for learners, and towards the development of their English and mathematics skills across all activities?

2.35 We found that leaders and managers had a clear focus on improving the quality of teaching, learning and assessment. Managers carried out effective quality improvement actions and the moderation of the lesson observation reports clearly identified areas for improvement and determined themes for staff development sessions. Consequently, tutors and instructors were improving their teaching.

2.36 Managers had ensured that tutors and instructors used information about prisoners' starting points and prior knowledge effectively to set practical, academic and personal development

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6 Ofsted's thematic approach reflects the monitoring visit methodology used for further education and skills providers. The themes set out the main areas for improvement in the last inspection report.

targets and goals with prisoners. However, in a few industries and work areas instructors did not set these targets consistently enough. Most tutors and instructors ensured that prisoners received individual targets focused on developing and improving their employability skills to reflect the key core competencies of team work, communication, presentation, problem solving and self-management. Almost all prisoners were aware of how they were developing these skills and how this would help them in their future lives and work and in their communities.

2.37 Prisoners gained valuable skills in English and mathematics during lessons and activities, for example, prisoners completing research projects used the encyclopaedia well to ensure that facts were correct. Peripatetic tutors routinely helped prisoners attending their activities to improve their mathematics skills appropriate to the tasks they were undertaking. This encouraged prisoners to engage in the development of their English and mathematics skills and to have greater appreciation of where they could use these skills in everyday life and future employment.

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

Theme 3: What progress have leaders and managers made in improving the reliability of the data they use to enable them to track the quality of prisoners' progress when they transfer to other prisons and to monitor achievements by prisoners ensuring that achievement rates in English improve?

2.39 At the time of the visit, leaders and managers had effective access to high-level achievement data for the few accredited qualifications offered. The introduction of the prisoner employability portfolios ensured that prisoners and their tutors had a useful understanding of the progress prisoners were making with their individual targets and goals. However, despite the recent introduction of a central data management information system, which had not yet been fully implemented, managers did not have an accurate understanding of the progress individuals or groups of prisoners made towards the achievement of their targets or goals.

2.40 The introduction of the employability portfolio and individual learning plan aimed to make the transfer to other establishments smooth and straightforward and enable prisoners to be allocated activities or suitable education swiftly on their arrival at their new prison. However, not all prisoners took their portfolios or information with them and managers had not yet evaluated the effectiveness of this initiative.

2.41 The proportion of prisoners who achieved their level 2 English qualifications had improved significantly since 2018. However, managers had made the strategic decision to concentrate on the development of prisoners' employability skills and engagement in activities and the number of prisoners challenged to progress to levels 1 and 2 had reduced significantly.

2.42 We considered that the prison had made insufficient progress against this theme.

Rehabilitation and release planning

Concern: Just over 10% of the population, and 38% of those sentenced to more than 12 months, presented a high risk of harm to others. Offender management of these prisoners, particularly those due to be released, was too variable and prison officer offender supervisors had little training. There was too little management oversight in these cases and risk management release planning was variable.

Recommendation: Offender management of prisoners presenting high risk of harm to others should be improved and should include adequate training for offender supervisors. High risk cases due for release should receive better management oversight from within the prison, and release planning with the community-based offender manager should be consistently good. (S46)

2.43 Improvements had been made to the method of allocating high risk of harm prisoners to offender supervisors. It was good to see that high or very high risk of harm cases were reviewed by the senior probation officer beforehand to determine if they should be allocated to a prison or probation officer offender supervisor.

2.44 Training for prison offender supervisors had also improved. A training needs analysis and training sessions for staff had been completed and there was an ongoing programme of development sessions. Prison offender supervisors had recently started supervision with the senior probation officer which included discussion of cases to aid professional development and provide management oversight of their cases.

2.45 However, our previous concerns about the quality of offender management remained. Contact in some cases, including high risk of harm prisoners, remained poor and was hindered by offender supervisors carrying out other operational duties across the prison.

2.46 In the cases that we reviewed too little attention was given to pre-release risk management planning. For example, two high risk of harm prisoners due to be released the week after this review told us that they did not know who their offender supervisor was and there was no evidence on P-Nomis of any pre-release planning with the community offender manager. This was a significant concern given the importance of ensuring that the public were protected from further harm by offenders when in the community.

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

Concern: The role of the interdepartmental risk management team was limited. There was no overview of prisoners assessed as high or very high risk of harm who were due to be released or those subject to multi-agency public protection arrangements (MAPPA). The prison did not routinely clarify the MAPPA management level before release. Shortfalls in risk management release planning were concerning because the prison could not provide assurances that all men likely to be a risk to the public were being sufficiently managed in conjunction with the community responsible officer before their release.

Recommendation: MAPPA management levels should be confirmed with the community-based offender manager at least six months to release. (4.25)

2.48 An important component of good release planning is agencies working together to share information and develop robust risk management plans to support the offender and protect the public from serious harm. Some prisoners are managed under MAPPA according to their offence and a key feature of good risk management planning is regular discussions between the offender supervisor and the community offender manager in the months leading up to

release to identify risks and put in place plans to manage the risks. In some cases, a referral to MAPPA level 2 or 3 management would be necessary when the risks were so acute that normal levels of risk management were not adequate. It is simply not sufficient for a prison to rely on sending a letter to the National Probation Service asking for confirmation of the MAPPA management level.

2.49 At this review we found that three-quarters of the MAPPA cases due for release in the next three months did not have a clear MAPPA management level. This indicated that offender supervisors and community offender managers had not had these very basic discussions to enable plans to be put in place for the release.

2.50 It was positive that an escalation process had very recently been implemented to help confirm MAPPA management levels where they had been requested. However, this still did not meet our expectation that offender managers in the community and offender supervisors in the prison had regular and meaningful discussions about release plans to agree necessary steps to protect the public, including the MAPPA management level.

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

Recommendation: The IDRMT should review all high and very high risk of harm cases prior to release to ensure appropriate action and restrictions are in place. (4.26)

2.52 At our 2018 inspection, we were concerned that the interdepartmental risk management team (IDRMT) was too limited, and this remained the case at this review. There had been attempts to improve its effectiveness, but it still did not provide adequate oversight of the release of prisoners and attendance at the meetings required improvement.

2.53 The IDRMT did not routinely discuss all MAPPA and high or very high risk of harm cases due for release in the next six months, which was an omission. Cases that were discussed were only discussed once and not brought back to the meeting to ensure that actions had been completed.

2.54 A comprehensive template had been developed to record discussions, but this was not yet fully embedded. Minutes of the meeting were not routinely shared with the community offender manager, which remained an omission.

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

Section 3. Appendix

Review team

Peter Clarke	Chief inspector
Sandra Fieldhouse	Team leader
Darren Wilkinson	Inspector
Caroline Wright	Inspector
Ian MacFadyen	Inspector
Steven Hunsley	Ofsted inspector
Stephen Oliver-Watts	Ofsted inspector