Report on an independent review of progress at

HMP Bedford

by HM Chief Inspector of Prisons

5–7 August 2019

This progress visit was carried out with the following body:

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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 28 August-6 September 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.

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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 https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2019/01/Bedford-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 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 since our inspection had not yet resulted in sufficient evidence of progress (for example, better and embedded systems and processes).

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

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

A9 When Ofsted attends an IRP its methodology will replicate the monitoring visits conducted in further education and skills provision.[3] 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.

A10 As part of this report we will also report on any good practice we find during our visit. Our definition of good practice is impressive practice that not only meets or exceeds our expectations, but could be followed by other similar establishments to achieve positive outcomes for prisoners.

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[3] Ofsted's approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook* at paragraphs 25 to 27, available at https://www.gov.uk/government/publications/further-education-and-skills-inspection-handbook

Key findings

S1 At this IRP visit, we followed up 13 of the 61 recommendations from 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 two recommendations, insufficient progress in six recommendations and no meaningful progress in two recommendations. A summary of the judgements is as follows.

Figure 1: Progress on recommendations from 2018 inspection (n=13)[4]

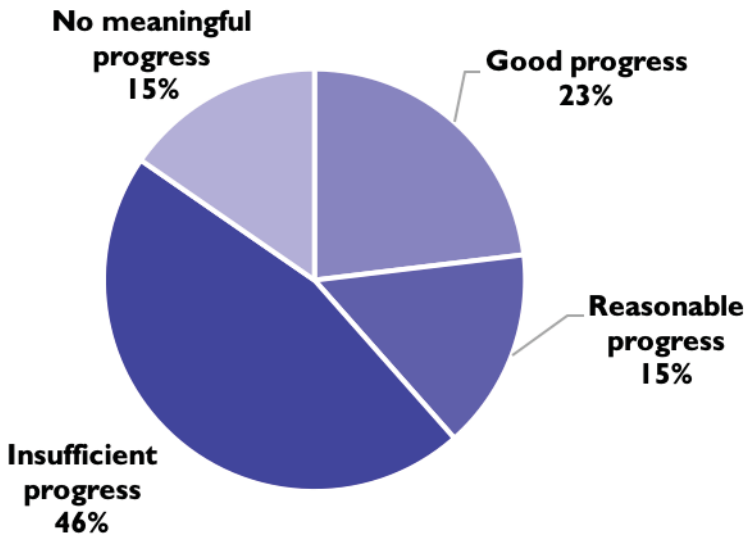


Figure 2: Judgements against HMI Prisons recommendations from 2018 inspection

Recommendation	Judgement
A time-bound action plan to reduce violence should be in place. This should include a range of sanctions and interventions to address violent behaviour and support victims, and actions should be monitored for effectiveness. (S62)	Insufficient progress
The adjudications process should be robustly managed, to increase the number of timely completions and ensure that it provides an effective deterrent to poor behaviour. (**1.20**)	Insufficient progress
Managerial oversight of the use of force should consider any use of batons or special accommodation. Patterns and trends should be identified and acted on, to ensure that force is used only when justified and is always proportionate. (1.25)	Insufficient progress
Prisoners held on the segregation unit or segregated on residential wings should be held in decent conditions and have access to a reliable and acceptable regime, including off-unit activities and association with others, when risk assessments permit. (S63)	Reasonable progress

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

Bedford's effort to reduce drug supply should be supported by investment in improving physical security and providing technological solutions. (S64)	Insufficient progress
Those at risk of self-harm should be properly supported, and triggers such as poor living conditions and isolation should be addressed. The care of those most at risk under assessment, care in custody and teamwork (ACCT) procedures should focus on their assessed needs through a well-managed and effective casework approach. (S65)	No meaningful progress
Action should be taken to improve staff skills and knowledge. Staff should be skilled and confident in confronting and controlling poor prisoner behaviour and should be supported in undertaking their role. (S66)	Insufficient progress
All prisoners should live in clean and decent conditions. (S67)	Good progress
Prisoners with disabilities should be identified and given good, consistent and organised support. (2.46)	Insufficient progress
Prisoners should have at least 10 hours out of their cells on weekdays, including some time in the evening. (3.8)	No meaningful progress
All prisoners requiring offender supervision should have good levels of contact. (4.16)	Good progress
All prisoners requiring offender assessment system (OASys) assessment should have an up-to-date risk assessment. (4.17)	Reasonable progress
Sentence calculations should be completed without delay and home detention curfew processes should be completed in a timely manner. (4.18)	Good progress

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

Figure 3: Judgements against Ofsted themes[5] from 2018 inspection

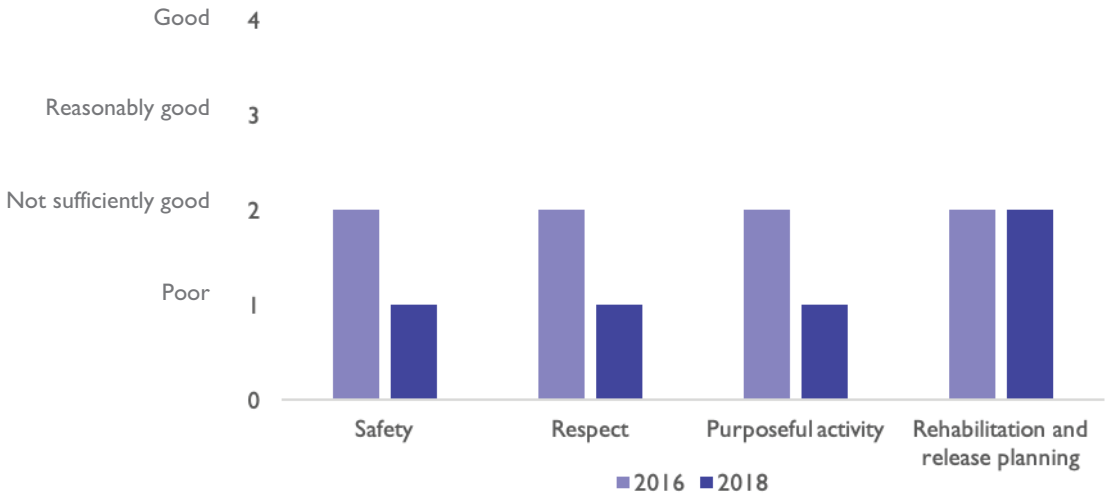
Ofsted theme	**Judgement**
What progress have leaders and managers made with strategies to promote and actively support the importance of education, skills and work through maximising the number of prisoners attending learning, skills and work?	Insufficient progress
What progress have leaders and managers made with their strategies to increase the range of provision, improve attendance and punctuality, and increase the proportion of prisoners who successfully complete their studies and gain their qualification?	Reasonable progress
What progress have leaders and managers made in improving the quality of teaching, learning and assessment through ensuring that prisoners attend initial assessment and through tutors planning and delivering challenging learning activities that enable prisoners to progress, including those with additional learning needs?	Reasonable progress

[5] 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 Bedford in August-September 2018 we made the following judgements about outcomes for prisoners.

Figure 4: HMP Bedford healthy prison outcomes 2016 and 2018



1.2 The inspection in August-September 2018 found that HMP Bedford had continued on a seemingly inexorable decline that was evident through the results of the four inspections carried out since 2009. Our inspection findings in 2018 showed outcomes for prisoners to be 'poor' in the areas of safety, respect and purposeful activity and 'not sufficiently good' in rehabilitation and release planning. I did not have confidence in the prison's capacity for change and improvement, even when under the HMPPS special measures programme, and so invoked the Urgent Notification protocol.

1.3 In the 2018 report we noted that the prison was fundamentally unsafe. Violence of all kinds had risen alarmingly in just two years, and there had been five self-inflicted deaths alongside increased levels of self-harm. The violence was largely fuelled by drugs, and the prisoners – many of them living in fear – were confined for unacceptable lengths of time in cells that were all too often infested with vermin, dirty and unfit to be occupied. Many staff were doing their best in difficult circumstances, but inspectors witnessed a dangerous lack of control and excessive tolerance of poor behaviour. Meanwhile, few prisoners attended work or education and there was little encouragement to do so by staff. Many prisoners milled about aimlessly on wings with nothing to do. In short, the prison lacked a culture of work or learning.

1.4 At this review visit we found a mixed picture with progress ranging from none to good, but in the majority of areas progress had been insufficient. The level of violence was still very high, and self-harm had increased dramatically over the last 11 months. Efforts to reduce violence had been limited and very slow to start. The attention given to preventing self-harm and supporting those in crisis was poor. Use of challenge, support and intervention plans (CSIPs)[6] and adjudications was not fully effective, which undermined behaviour management in the eyes of some prisoners and staff. Use of force was exceptionally high and needed

[6] Used to manage the most violent prisoners and support the most vulnerable prisoners in the system. Prisoners who are 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.

immediate attention to identify the reasons why. Despite significant efforts, illicit drugs continued to be a major problem, and the lack of a body scanner to detect drugs was indefensible.

1.5 Living conditions, including in the segregation unit, had improved, as had prisoner access to basics such as bedding and furniture, but Bedford remained an unsuitable location for prisoners with severe physical mobility problems.

1.6 Staff training had been a focus since our inspection but some staff lacked the confidence to challenge poor behaviour, which only served to promote a view commonly held by prisoners that such behaviour was acceptable.

1.7 There had been no increase in the time that prisoners had out of their cell for association, outdoor exercise and completing domestic tasks. Ofsted judged there to be sufficient progress in two of the three themes it reviewed. Progress in the three areas of rehabilitation and release planning that we reviewed was reasonable or good.

1.8 It was clear that progress in addressing the serious issues I raised in the Urgent Notification issued in September 2018 had been hampered because the prison had been far too slow in taking remedial action. A new governor took up post in January 2019 and had to take some time to assess what he found and draw up his own plans. The result was that it took around six months before the prison started to make any properly focused response to the Urgent Notification. This is not the first time I have had to comment on the slow response to an Urgent Notification. At Bedford, urgent action should have been driven by the clear threats to the safety of staff and prisoners identified during our inspection. The slowness of the response is difficult to understand.

1.9 I have looked at the various action plans that were drawn up centrally in HMPPS in response to the Urgent Notification. They were almost entirely focused on management inputs and process rather than the poor or dangerous outcomes that gave rise to the Urgent Notification in the first place. For instance, the section in the 'Urgent Notification: initial action plan' that is supposed to address the issues of suicide and self-harm refers almost exclusively to reviewing and reinforcing existing processes. The updated plan from July 2019 simply talks about inputs and does not provide any evidence of changes in outcomes. There was no requirement to explore or analyse the specific issues underpinning the high levels of self-harm at Bedford. Meanwhile, the rate of self-harm had increased dramatically.

1.10 We found a lack of clarity about the purpose and ownership of the various plans. There was far too little linkage between the centrally generated initial action plan and HMIP recommendations. There is a real need for the corporate HMPPS response to Urgent Notifications to become prompt, focused on specific HMIP recommendations and regularly monitored against outcomes.

1.11 It is to the credit of the leadership at Bedford that they have generated their own plans that are focused on the specific issues affecting the prison, and are much more closely aligned to the concerns expressed by HMIP. There has not yet been time for them to have the desired impact, but at least there is now encouraging progress in some areas.

Peter Clarke CVO OBE QPM August 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.

Managing behaviour

Concern: Levels of violence were very high and perpetrators of violence faced few sanctions or interventions. The causes of violence were well understood but the prison lacked a dynamic, measurable action plan.

Recommendation: A time-bound action plan to reduce violence should be in place. This should include a range of sanctions and interventions to address violent behaviour and support victims, and actions should be monitored for effectiveness. (S62)

2.1 Rates of violence remained very high and some incidents were serious. According to prison data, the rates of violent incidents remained very similar to those at our inspection in 2018, and were still much higher than we find in other local prisons.

2.2 Staffing issues had hindered progress. For example, since the 2018 inspection, the senior manager responsible for safety had been replaced four times, and the middle manager was frequently redeployed to other work. While it was positive that a safety analyst had recently been appointed, the prison lacked a dedicated violence reduction officer to support day-to-day work in this area.

2.3 Progress in developing a local strategy and action plan to reduce violence had been slow. The prison's violence reduction policy and associated action plan were only published in June 2019 and, while both evidenced a sensible approach to reducing the rate of violence, it was too early to assess if they would have a positive impact. The action plan identified a range of sanctions and interventions, but these needed to be embedded in practice and monitored for effectiveness.

2.4 The challenge, support and intervention plan (CSIP) process (see footnote 6) had been implemented. There had been 164 referrals in the first six months of 2019 but it was concerning that over half did not record action, which meant that the challenge of perpetrators and support for victims was not effective. This also undermined wing staff attempts to manage poor or violent behaviour (see section on staff-prisoner relationships).

2.5 There were seven CSIPs open at the time of our review visit. The quality of these was poor, lacking detailed management plans and regular reviews. The day-to-day management of perpetrators and support for victims were poor.

2.6 Following the 2018 inspection, the prison had received support visits from the HMPPS national safety team. The team had helped the prison to hold a violence summit attended by senior staff and partner agencies in late 2018. This could have been a useful foundation to address current concerns, but the actions identified from the event were not passed to the head of violence reduction until the week of this review visit. Similarly, issues identified by the HMPPS lead for CSIP in early July 2019 were yet to be fully addressed.

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

Adjudications

Concern: The adjudications process was not used effectively to challenge poor prisoner behaviour. In the previous six months, only around one-third of adjudications had been completed.

Recommendation: The adjudications process should be robustly managed, to increase the number of timely completions and ensure that it provides an effective deterrent to poor behaviour. (**Error! Reference source not found.**)

2.8 Measures to improve the management of adjudications through quality assurance had been introduced in February 2019. These included regular reviews of completed adjudications, the identification of training needs for adjudicating governors, and the training of segregation staff as adjudication liaison officers.

2.9 While these improvements were positive, more progress was needed to ensure that disciplinary procedures were an effective deterrent to poor behaviour. For example, the number of remanded adjudications remained high with over 100 adjournments at the time of the review visit. The prison's data evidenced that almost a third of adjudications were not proceeded with or dismissed due to procedural irregularities, including some charges of serious offences such as acts of violence. We also found that cases dismissed included possession of illicit items, such as an improvised weapon or mobile telephone, even though the prisoner admitted knowledge, presence and control of the items. This undermined the authority of wing staff and potentially left prisoners' poor or violent behaviour unpunished (see also section on staff-prisoner relationships).

2.10 We considered that the prison had made insufficient progress in this area.

Use of force

Concern: Levels of use of force were very high, and much higher than at the time of the previous inspection and at similar prisons we have recently inspected. Baton use was high. We found evidence of numerous occasions where special accommodation had been used but not recorded. Although there was some analysis of available data to identify hotspots and trends, managerial oversight was inadequate and the use of force committee did not review video recordings or incident paperwork. Almost all dossiers were incomplete and none included an 'injury to prisoner' form.

Recommendation: Managerial oversight of the use of force should consider any use of batons or special accommodation. Patterns and trends should be identified and acted on, to ensure that force is used only when justified and is always proportionate. (Error! Reference source not found.)

2.11 Despite some evidence of improved management oversight, the use of force had increased since the 2018 inspection and was now much higher than we have seen in similar prisons.

2.12 A weekly meeting now reviewed use of force incidents, including video footage and staff statements. Resource issues limited reviews to just two incidents a week but minutes of meetings showed that learning from these was taken forward. Data were discussed monthly but there was little evidence that they were used to identify patterns and trends. Where actions were identified, too often it took several weeks before they were completed.

2.13 The use of special accommodation had declined and it had only been used once in 2019 to date. The use of batons remained high with 12 recorded incidents during the previous six months. Documentation evidenced that in most incidents staff removed batons from their holster but this did not result in strikes to the prisoner. Managers were aware of these concerns and reviewed all baton use to ensure it was necessary.

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

Segregation

Concern: The conditions and regime experienced by prisoners on the segregation unit and those segregated on normal location were appalling. The unit was chaotic and managerial oversight was lacking.

Recommendation: Prisoners held on the segregation unit or segregated on residential wings should be held in decent conditions and have access to a reliable and acceptable regime, including off-unit activities and association with others, when risk assessments permit. (S63)

2.15 The living conditions and regime in the segregation unit had improved since the inspection (see Appendix II: Photographs). Toilets and sinks had been replaced and there was a regular painting programme. New LED lighting helped to overcome the lack of natural lighting in the unit.

2.16 The daily regime for prisoners, while basic, was consistent and included access to a shower, telephone and exercise. Reintegration planning took place where possible, and we saw some prisoners associating with others on the main wings as part of this.

2.17 Despite improvements to the daily management of the unit, the strategic management of segregation remained limited. The segregation monitoring and review group (SMARG) had met only a couple of times in the 11 months since our inspection, which was poor. However, an experienced custodial manager had recently taken up post to improve data collation and the SMARG.

2.18 Unlike at our 2018 inspection, no prisoners were segregated on residential wings during our review visit. However, there was no local policy for the management of such prisoners and no accurate records to evidence when this had last happened.

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

Security

Concern: Drugs were easily available. A good local supply reduction strategy and action plan was in place but it was hampered by a lack of funding and investment in available technology (such as Rapiscan and body scanners) nationally to assist in drug detection and supply reduction.

Recommendation: Bedford's effort to reduce drug supply should be supported by investment in improving physical security and providing technological solutions. (S64)

2.20 The prison had reviewed its local drug strategy, which was now based on a prison needs analysis. A revised action plan supported the strategy, and minutes of substance use meetings evidenced attendance by the functional lead officers for security and reducing reoffending.

2.21 The governor had engaged positively with the local community neighbouring the prison and made effective links with the police and community leaders. These were examples of good practice to reduce the flow of drugs into the prison. Prison managers had improved physical security to reduce the entry of drugs and other illicit items. For example, there was a cell window replacement scheme for the most vulnerable areas of the prison, and netting had been installed over the all-weather pitch, which meant it could once again be used.

2.22 The prison was now using a machine to identify substances entering the prison through the mail, although a shortage of staff trained in its use meant the machine was not used to full effect. The prison did not have sufficient staff to photocopy all mail but had sensibly targeted resource to identified risk areas. An X-ray machine had been installed to support the searching of staff and visitors' property, although the lack of a full body scanner affected the prison's ability to reduce the supply of drugs.

2.23 Despite the improvements in technology and supply reduction strategies, positive drug testing rates were still among the highest of all local prisons, and there was a strong smell of drugs in parts of the prison. There were major weaknesses in the mandatory drug testing (MDT) programme. For example, too many MDTs were not completed, and there was a lack of focus on suspicion or frequent testing programmes for prisoners suspected of using drugs.

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

Self-harm and suicide prevention

Concern: Care for prisoners in crisis and at risk of self-harm was weak. ACCT procedures to meet the needs of those most at risk were poorly managed and were ineffective. Many experienced poor living conditions, without access to activities, and were locked in their cells for long periods.

Recommendation: Those at risk of self-harm should be properly supported, and triggers such as poor living conditions and isolation should be addressed. The care of those most at risk under assessment, care in custody and teamwork (ACCT) procedures should focus on their assessed needs through a well-managed and effective casework approach. (S65)

2.25 There had been no self-inflicted deaths since our inspection in 2018 but the recorded number of self-harm incidents was very high and had increased dramatically. There had been 280 incidents in the first six months of 2019, compared with 163 in the six months before the 2018 inspection. Given the current decrease in the population at Bedford, this represented a doubling in the rate of self-harm and, according to HMPPS data, the rate was now the second highest of all local prisons.

2.26 Work to address weaknesses in suicide and self-harm prevention processes had been far too slow to develop following the Urgent Notification issued in September 2018. Leadership of safer custody had been weak, having been led by four different managers since the inspection. A strategy had only just been published but even this did not adequately address the unique challenges faced by the prison. Detailed analysis of information to evidence the causes of self-harm was very limited, although the recent recruitment of an analyst to begin this was positive. There were plans to recruit safety officers to investigate the causes of self-harm and prisoners' perceptions of the support they received. The prison did not measure progress to understand if its actions to reduce self-harm were effective.

2.27 There remained fundamental weaknesses in the completion of ACCT case management for prisoners at risk of suicide or self-harm. In particular, care maps were not always used effectively to deliver the right support. There were not enough ACCT assessors or case

managers, and there was no local ACCT quality assurance process. There was also no system for ensuring multidisciplinary attendance at case reviews.

2.28 We were still not assured that prisoners in crisis were properly supported. Time out of cell had not improved (see paragraph 2.44) and prisoners, including those at risk of self-harm, could be locked up for 27 hours at weekends without any meaningful time out of cell, association or activity.

2.29 Living conditions on the wings had improved and there had been some recent efforts to prioritise purposeful activities for prisoners on ACCT support, but these were inconsistently applied. There had been persistent, unresolved issues about the lack of prisoner access to the Samaritans telephone line and a safer cell for constant supervision. Staff responses to too many cell call bells were not prompt, which was an additional concern.

2.30 We considered that the prison had made no meaningful progress against this recommendation.

Staff-prisoner relationships

Concern: Officers were exceptionally inexperienced. Most were committed to their work, trying to do their best, but as a group were out of their depth. Prisoners routinely and blatantly disregarded rules and appropriate standards of behaviour, without challenge. We often observed prisoners refusing to do as instructed by staff – and getting away with it. Poor supervision and control of prisoners created unacceptable risks and, at times, control was tenuous.

Recommendation: Action should be taken to improve staff skills and knowledge. Staff should be skilled and confident in confronting and controlling poor prisoner behaviour and should be supported in undertaking their role. (S66)

2.31 The prison officer group remained relatively inexperienced, with half having less than a year in service. There had been a range of work to upskill staff and improve their confidence in doing the job. This included mentoring, training events and the production of a 'how to' guide, as well as the very recent introduction of coaching by HMPPS staff.

2.32 Although some experienced custodial managers from other prisons had been allocated to Bedford temporarily, there was a lack of experienced middle managers to hold officers to account and support them in their day-to-day work. It was clear at this review visit that some officers struggled with implementing rules consistently and/or lacked knowledge about the very basic aspects of life in the prison.

2.33 In the two days we were on site for this review we saw many examples of rule breaking by prisoners that were not challenged by staff, and a culture among some prisoners that promoted disrespect for staff and their authority. While much of this was low-level rule breaking (such as vaping on the wings and being inappropriately dressed while out of cell) it contributed to prisoners' perceptions that staff lacked control.

2.34 Prisoners appeared to have little to fear from behaving badly. Some staff were reluctant to challenge rule breaking because they felt that the formal procedures to address prisoners' poor behaviour (such as CSIP, use of the incentives scheme, adjudications and drug testing) were not effective. In this permissive culture of poor behaviour, prisoners felt able to push the boundaries further - such as refusing to return to their cell at lock-up time or creating chaos when returning to units from outdoor exercise. If not managed consistently and firmly, this negative behaviour had the potential to escalate, as we had witnessed during the inspection in 2018.

2.35 We considered that the prison had made insufficient progress against this recommendation and needed to do more to ensure wing staff were supported in enforcing the rules and challenging poor behaviour.

Living conditions

Concern: Living conditions were very poor, often overcrowded, dirty and vermin infested.

Recommendation: All prisoners should live in clean and decent conditions. (S67)

2.36 Although the prison's population had reduced since our 2018 inspection, Bedford remained overcrowded, with a quarter of prisoners still sharing cells originally designed for one.

2.37 There had been major improvements in reducing the number of maintenance repairs waiting to be completed, and a refurbishment programme was well under way. This had already resulted in positive improvements on some wings, such as the refurbished showers on D wing (see Appendix II: Photographs). There was now funding for the refurbishments to continue.

2.38 Prisoners said that the infestation of rats was now more under control but the problem with cockroaches continued. We found that outside areas were cleaner, with far less rubbish than at our 2018 inspection. Communal areas inside the prison were also cleaner but some cells remained grubby. A member of staff on each wing had been appointed as a cleaning officer to promote wing cleanliness, and managers made daily decency checks to ensure prisoners had access to appropriate kit, such as bedding, kettles and furniture.

2.39 Prisoners had better access to cleaning materials. A new weekly clothing exchange system had been introduced but some outstanding issues with its implementation needed addressing.

2.40 We considered that the prison had made good progress in making living conditions more decent.

Equality, diversity and faith

Concern: There was no assurance that prisoners with disabilities had their basic needs met, and there were no care plans other than for those prisoners living on the inpatient unit. Many staff were unaware of evacuation procedures for those with disabilities. A few with substantial disabilities were living in very poor conditions.

Recommendation: Prisoners with disabilities should be identified and given good, consistent and organised support. (2.46)

2.41 The profile of equality work had improved and there were additional resources to provide strategic oversight, alongside some dedicated administrative support. As a result, the identification of prisoners with disabilities had improved. However, Bedford remained an unsuitable environment for prisoners with severe mobility problems. For example, prisoners using wheelchairs could not access the education building, chapel or the showers on some wings.

2.42 There was still no formal system for peers to provide support to prisoners with disabilities which was a gap. A disability forum to seek the views of disabled prisoners had very recently been reintroduced, which was positive although too early to assess the outcomes.

2.43 Health care staff developed care plans for prisoners who needed support, although residential staff lacked awareness of these. The prison now had links with the local authority to make social care referrals, and a memorandum of understanding had been agreed. There had been two referrals to the local authority for social care provision and assessments had been completed promptly.

2.44 The development of personal emergency evacuation plans was now included as part of the early days assessment for prisoners with disabilities who needed them, and the plans were checked by the equality team. Residential staff were aware of the prisoners on their unit who had evacuation plans and understood the support they needed. However, the plans were not always regularly reviewed to ensure they were up to date, which was a gap.

2.45 We considered that the prison had made insufficient progress in this area.

Time out of cell

Concern: The amount of time out of cell was poor and few prisoners used it constructively, mostly spending it on the wings with nothing purposeful to do. Too many prisoners, around 39%, were locked in their cells during the working day. A restricted regime had been in place for many months, which was intended to provide limited but reliable time out of cell, but there were often long delays in locking and unlocking prisoners and moving them to activities.

Recommendation: Prisoners should have at least 10 hours out of their cells on weekdays, including some time in the evening. (**Error! Reference source not found.**)

2.46 The regime had not changed since our inspection in 2018 and remained restricted. Prisoners still had too little time out of cell during the day, no evening association and extremely long periods locked up at weekends. For example, prisoners on A wing could be locked behind their door for 27 hours from Friday lunchtime to Saturday afternoon. A re-profiling exercise was due to review the core day.

2.47 At our 2018 inspection, we found 39% of prisoners locked in their cells during the core working day, which was far too high. On this visit, the proportion involved in purposeful activity had increased slightly and we found that 25% of prisoners were locked in their cell during the core working day. This was positive progress but could be improved further.

2.48 We were astonished that some staff and prisoners said they did not know the scheduled lock-up and unlock times prescribed by the current schedule for the core day. There were some delays in unlocking prisoners, particularly in the afternoon, which added to prisoners' frustrations and late arrivals to work, training and education.

2.49 We considered that the prison had made no meaningful progress against this recommendation.

Education, skills and work[7]

Theme 1: What progress have leaders and managers made with strategies to promote and actively support the importance of education, skills and work through maximising the number of prisoners attending learning, skills and work?

2.50 There had been no meaningful action for several months after the Urgent Notification was issued in September 2018. The new governor, appointed in January 2019, had recently begun to implement a range of promising initiatives to promote the importance of education, skills and work. However, the impact of most of these initiatives had yet to be assessed.

2.51 In April 2019, the prison commissioned a private company to provide careers advice and guidance. This resulted in prisoners receiving clear guidance during their induction about how they could use their time in custody productively to improve their prospects of resettlement. Prisoners approaching their release date received help with writing a CV and could attend sessions on job interview skills. It was too soon to judge the impact of this work.

2.52 The number of prisoners engaged in purposeful activity was still too low. Two recent activity engagement days had encouraged prisoners to register their interest in enrolling on an education course, and had resulted in an increase in prisoners expressing an interest in attending.

2.53 The prisoner pay policy had been revised in May 2019 to reflect the commitment to promoting the value of education. Prisoners participating in education now received a higher rate of pay than those attending other purposeful activity. However. it was too soon to assess the impact of this change.

2.54 In the previous three months, induction arrangements had been revised to ensure that prisoners received comprehensive information about the opportunities for engaging in purposeful activity. They received better information about the options available to them, including opportunities to work as a peer mentor, orderly or in the kitchens. However, it was too soon to assess the full impact of the improved induction arrangements.

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

Theme 2: What progress have leaders and managers made with their strategies to increase the range of provision, improve attendance and punctuality, and increase the proportion of prisoners who successfully complete their studies and gain their qualification?

2.56 Managers had worked well to increase the range of provision. Staff ensured that prisoners who attended activity sessions were fully engaged throughout. Prisoners could now attend courses in painting and decorating, independent living skills and preparation to apply for construction jobs on building sites. There were well-developed plans to increase the range of vocational courses further.

[7] 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.

2.57 Attendance at educational and vocational training had improved since the September 2018 inspection, from 48% to 68%. This was a considerable achievement, although it needed to improve further. However, punctuality was often poor, especially in the afternoons when regime slippage often meant prisoners were unlocked up to 30 minutes later than scheduled. This resulted in late arrivals at education, reducing learning time.

2.58 A 'passport to employment' had been introduced for prisoners in prison jobs. This was used to record the development of vocational skills, as well as attitude, work ethic, performance and outcomes. It was too soon to assess its effectiveness in helping prisoners to gain employability skills and reducing their likelihood of reoffending.

2.59 The proportion of prisoners gaining a qualification, particularly in English and mathematics, had improved from a very low starting point and was now close to national averages. Managers had introduced a promising initiative to integrate English and mathematical skills in the painting and decorating workshop. Early indications were that this approach was well-received by prisoners.

2.60 The high proportion of prisoners removed from education to transfer to other prisons often resulted in them failing to complete their studies. However, the achievement rate for prisoners who completed their studies was generally good.

2.61 Work in the small commercial packing workshop was mundane and repetitive. Managers did not set suitably challenging individual targets for prisoners and did not monitor their work to ensure that they met commercial standards.

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

Theme 3: What progress have leaders and managers made in improving the quality of teaching, learning and assessment through ensuring that prisoners attend initial assessment and through tutors planning and delivering challenging learning activities that enable prisoners to progress, including those with additional learning needs?

2.63 The overall quality of teaching, learning and assessment had improved considerably since the 2018 inspection, but there remained some areas for improvement. Teachers planned lessons well and made suitable use of the available information on prisoners to devise strategies to challenge and motivate them.

2.64 In lessons, prisoners learned well, participated in activities and demonstrated good behaviour. Teachers' confidence in managing classroom discipline had improved. The occasional instance of poor behaviour, particularly use of inappropriate language, was challenged when necessary. In a few sessions, teachers failed to reinforce and consolidate learning points, which resulted in a few prisoners being unable to articulate clearly what they had learned.

2.65 Robust performance management had resulted in the departure of several underperforming teachers and managers. The education manager ensured that observations of teaching and learning resulted in accurate and detailed assessments of the quality of teaching and learning for prisoners. Managers used the results of observations to help the few weaker teachers improve their professional practice.

2.66 The backlog of prisoners who had yet to complete an initial assessment of their English and mathematics had declined since the inspection but was still too high. Education managers were aware of this issue and taking appropriate actions to reduce still further the number of prisoners awaiting initial assessment.

2.67 Education managers now ensured that prisoners with special educational needs were identified promptly and given suitable support to help them progress and achieve as well as their peers. A newly appointed learning support practitioner provided effective support to prisoners with a wide range of barriers to learning, such as dyslexia, attention disorders, and anxiety and depression. These prisoners were making reasonable progress with their studies.

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

Rehabilitation and release planning

Concern: About 40% of the offender management unit (OMU) caseload was managed by uniformed offender supervisors. These low- and medium-risk prisoners received a poor service. Only four out of six uniformed offender supervisor posts were filled and they were consistently redeployed to other duties in the prison. This meant that, typically, only one uniformed offender supervisor was available in the OMU each day. The prisoners they supervised received little or no ongoing contact, particularly if they had transferred into the prison when they did not even meet them at the initial screening. There were no OMU wing surgeries to offset these gaps in provision.

Recommendation: All prisoners requiring offender supervision should have good levels of contact. (4.16)

2.69 Prison offender managers (previously offender supervisors) no longer had other operational responsibilities across the prison and so were not cross-deployed to duties away from the OMU. This meant that the frequency of their contact with prisoners had improved, but in the cases we checked contact still required further improvement as it tended to be mainly in reaction to sentence events or requests from the prisoner. The current team of prison offender managers had been newly recruited at the start of 2019 and had so far lacked adequate supervision and management oversight. They had just started to receive guidance from the senior probation officer about levels of contact, and OMU managers needed to provide an ongoing focus on the frequency and quality of contact. Probation offender managers based in the prison generally had good contact with their prisoners.

2.70 The introduction of weekly OMU surgeries on all wings was very positive and had prompted much of the recorded contact in the cases we reviewed. Prisoners could drop into these surgeries and we saw actions resulting from these contacts. Three-quarters of the prisoner population had a key worker,[8] and contact between them also helped to allay many frustrations related to sentence planning.

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

Concern: About 40% of all eligible prisoners did not have an up-to-date OASys (offender assessment system) assessment to manage their risk or inform their sentence plan. Many others had transferred into the establishment without an assessment to inform their move. Managers had instructed staff that, due to staff shortages, they should no longer complete the OASys risk assessments allocated to them.

Recommendation: All prisoners requiring offender assessment system (OASys) assessment should have an up-to-date risk assessment. (4.17)

[8] Introduced under the Offender Management in Custody (OMiC) model, prison officer key workers aim to have regular contact with named prisoners.

2.72 Due to the reduced population at Bedford, the number of sentenced prisoners needing an OASys assessment was lower than at the 2018 inspection. There were 114 eligible prisoners at the time of this visit, a reduction of about 25% in demand for OASys completion.

2.73 Prison offender manager completion of prison OASys assessments, which had ceased in 2018, had now resumed, which was positive, and there was no significant backlog at the time of our review visit. Just over half of the outstanding assessments were the responsibility of the OMU staff, but most of these prisoners had arrived at Bedford in the last month and so the assessments were not yet late.

2.74 However, the absence of an OASys backlog at Bedford was partly the result of prisoners transferring to other prisons without one. Moving on without an assessment and sentence plan was a concern, as it could hinder the prisoner's progression and their chances of being located at a prison that could meet their offending-related needs.

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

Concern: Basic, but critical, offender management unit administrative tasks were often completed late and were sometimes carried out poorly. In one week in August 2018, 53 prisoner records were waiting to be processed. Sentence calculations were sometimes not promptly completed on P-Nomis, the Prison Service IT system. This meant that inexperienced residential staff were unable to provide prisoners with reliable, up-to-date information about release and home detention curfew (HDC) dates, adding to frustration on the wings. As a result of these problems, HDC processes sometimes began late and were not managed effectively. Only 24 prisoners had been approved for HDC in the previous six months; although this was more than at the previous inspection, it was lower than we would expect to see under the new, streamlined processes. It was a concern that some prisoners who should have been considered for HDC were not.

Recommendation: Sentence calculations should be completed without delay and home detention curfew processes should be completed in a timely manner. (4.18)

2.76 The OMU hub manager carried put weekly quality assurance checks of basic administrative tasks, which was an improvement, and sentence calculations were now completed without delay, which was much better than at our 2018 inspection.

2.77 HDC processes within the control of the prison were mostly well managed. The OMU hub manager regularly checked to ensure that all eligible prisoners were considered for HDC. Checks were mostly made promptly once the eligibility date was calculated, and in most cases the prisoner was quickly asked for a potential release address, which was submitted to the offender manager in the community for approval. However, we found a few mistakes by case administrators, which delayed the process. These errors had usually been identified by managers and training had already been given to these staff, which was positive.

2.78 Only 20% of prisoners considered for HDC were approved, which was much lower than at similar prisons, and too many of them were approved after their eligibility date. The reasons for this were often beyond the control of the OMU, such as delays in receiving approval from the community offender manager. OMU managers needed to explore and address the low number of prisoners released on HDC.

2.79 With the smaller prison population there were now enough case administrators to manage the current workload. However, both inspectors and OMU had concerns that a future increase in the population could jeopardise this progress.

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

Section 3. Appendix I: Review team

Peter Clarke	Chief Inspector
Sandra Fieldhouse	Team leader
Ian Dickens	Inspector
Jonathan Tickner	Inspector
Caroline Wright	Inspector
Darryl Jones	Ofsted inspector
Jai Sharda	Ofsted inspector

Appendix II: Photographs

The refurbished segregation unit

Outside areas now much cleaner

Progress on showers: D wing showers in 2019 following refurbishment compared with conditions in 2018