Report on an independent review of progress at

HMP Swaleside

by HM Chief Inspector of Prisons

30 September – 2 October 2019
This progress visit was carried in partnership with:

Ofsted

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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 [MONTH, YEAR] 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.

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/
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.

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.

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[^3]: Ofsted’s approach to undertaking monitoring visits and the inspection methodology involved is set out in its guidance on ‘Further education and skills inspection handbook’, available at: https://www.gov.uk/government/publications/further-education-and-skills-inspection-handbook-eif
Key findings

S1 At this IRP visit, we followed up 12 of the 50 recommendations made at our most recent inspection and made judgements about the degree of progress achieved to date. Ofsted followed up three themes based on their findings at our recent inspection.

S2 We judged that there was good progress in two recommendations, reasonable progress in two recommendations, insufficient progress in four recommendations and no meaningful progress in four recommendations. A summary of the judgements is as follows.

Figure 1: Progress on HMI Prisons recommendations from 2018 inspection (n=12)4

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4 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 December 2018 inspection

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMPPS and the prison should develop a strategy that reduces the level of harm presented by prisoners convicted of a sexual offence; progresses them through their sentence; and protects the public during custody and on release. (S43)</td>
<td>Insufficient progress</td>
</tr>
<tr>
<td>Prisoners should be and feel safe. The management of violence reduction should include input from all relevant agencies; be informed by accurate data; include prompt and robust investigations; and draw existing initiatives together in a coherent way. (S39)</td>
<td>No meaningful progress</td>
</tr>
<tr>
<td>Special accommodation should only be used in extreme circumstances and as a last resort. It should always be properly authorised and justified, and prisoners should be returned to normal conditions as soon as possible. The practice of routinely stripping prisoners of their clothing should cease. (S40)</td>
<td>No meaningful progress</td>
</tr>
<tr>
<td>Prisoners should spend sufficient time out of their cells and engage in activities that support their rehabilitation. Attendance and punctuality in education, training and work should significantly improve so that they are good. (S41)</td>
<td>No meaningful progress</td>
</tr>
<tr>
<td>Prisoners should be helped to reduce their likelihood of reoffending and their risk of harm should be managed effectively. Prisoners should have regular contact with an offender supervisor and an up-to-date OASys document to help them address their offending behaviour and ensure their progression is monitored effectively. (S42)</td>
<td>Insufficient progress</td>
</tr>
<tr>
<td>The supply of illicit drugs should be greatly reduced. The drug strategy should be fully embedded and senior managers should monitor its efficacy over time. (1.41)</td>
<td>Good progress</td>
</tr>
<tr>
<td>Strategic action to prevent suicide and self-harm should address the specific needs of Swaleside prisoners, take account of local trend analysis and be monitored over time against an up-to-date action plan. (1.51)</td>
<td>No meaningful progress</td>
</tr>
<tr>
<td>There should be visible leadership on the wings, to support inexperienced staff and model appropriate standards. (2.4)</td>
<td>Reasonable progress</td>
</tr>
<tr>
<td>Prisoners should be provided with decent and respectful living conditions. (2.12)</td>
<td>Insufficient progress</td>
</tr>
<tr>
<td>Work to reduce reoffending should be informed by a needs analysis based on an accurate, up-to-date range of data. Progress should be routinely measured against an action plan by senior managers. (4.21)</td>
<td>Insufficient progress</td>
</tr>
<tr>
<td>Monthly public protection meetings should routinely consider all high-risk prisoners and those due for release who will potentially be subject to multi-agency public protection arrangements (MAPPA) arrangements in the community. MAPPA management levels should be confirmed far enough ahead of release to ensure that effective supervision arrangements can be implemented. (4.26)</td>
<td>Good progress</td>
</tr>
<tr>
<td>There should be enough places on accredited offending behaviour programmes to meet the needs of the population. (4.38)</td>
<td>Reasonable progress</td>
</tr>
</tbody>
</table>

S3 Ofsted judged that there was insufficient progress in three themes.
### Figure 3: Judgements against Ofsted themes from December 2018 inspection

<table>
<thead>
<tr>
<th>Ofsted theme</th>
<th>Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>What progress have leaders and managers made with their strategies to ensure that the process of allocations maximises the use of activity spaces and prioritises prisoners’ development of English and mathematical skills, ensuring that the education, skills and work needs of different groups of prisoners are met, and that they can access a suitable range of accredited and non-accredited qualifications?</td>
<td>Insufficient progress</td>
</tr>
<tr>
<td>What progress have leaders and managers made in ensuring that prisoners develop an effective range of employment-related skills throughout the provision of education, skills and work?</td>
<td>Insufficient progress</td>
</tr>
<tr>
<td>What progress have leaders and managers made in ensuring that they identify and monitor the quality of progress made by prisoners who are not undertaking an accredited qualification, and in raising the achievement rates in English, mathematics, and information and communications technology courses?</td>
<td>Insufficient progress</td>
</tr>
</tbody>
</table>

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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 Swaleside in 2016 and 2018, we made the following judgements about outcomes for prisoners.

Figure 4: HMP Swaleside healthy prison outcomes 2016 and 2018

<table>
<thead>
<tr>
<th>Outcome</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Reasonably good</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Not sufficiently good</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Poor</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

1.2 HMP Swaleside, located on the Isle of Sheppey, in Kent, is a category B training prison with capacity for approximately 1,100 prisoners. Opened in 1988, the prison holds prisoners serving long sentences, including lifers, for often violent offences, as well as prisoners convicted of sexual offences. The prison is complex and challenging to manage. Many prisoners present risks to the public, staff and other prisoners.

1.3 At our inspection of Swaleside in 2018, we found a prison where progress had been lopsided. We judged safety and respect to be better than at the 2016 inspection but work to rehabilitate prisoners and plan for their release had deteriorated. In 2018, levels of violence had increased considerably and many prisoners told us that they felt unsafe. Action to address suicide and self-harm was also weak. Special accommodation was used far too often, for too long and often without effective managerial oversight. Illicit drug use was a fundamental problem, with a quarter of prisoners testing positive in random drugs tests. Relationships between staff and prisoners were generally very good but many prison officers had only just been recruited and many lacked the authority to challenge antisocial behaviour by prisoners. Many elements of the living conditions were poor, with dirty communal areas, uneaten food left out overnight and very poor shower units. The prison was failing in its fundamental role as a training prison. The quality of teaching and instruction were good and the achievement of qualifications was high, but this was all undermined by poor attendance, punctuality and allocation to activities. Too many prisoners were unemployed and locked in their cells during the working day. The poorest outcomes for prisoners were to be found in our test on rehabilitation and release planning. The prison was not adequately assessing prisoners’ risks, acting to reduce those risks or protecting the public.

1.4 At this independent review of progress, we found that not enough had been done to meet these concerns. Of our 12 key recommendations, the prison had made good progress in
two, reasonable progress in two, insufficient progress in four and no meaningful progress in four. Our Ofsted colleagues gave their lowest judgement – insufficient progress – across all three themes that they reviewed. It was notable that the prison had made no meaningful or insufficient progress in the five main recommendations highlighted in the 2018 inspection report.

1.5 Overall, the number of violent incidents remained high, and similar to that found at the time of the inspection. Despite this, managers had not thought hard enough about what was driving violence at the establishment. There was no meaningful strategy or action plan to reduce levels of violence. Likewise, there had been no reduction in the number of self-harm incidents, yet managers had not developed a strategy or action plan to address this problem. Tragically, there had been one suspected suicide since the inspection. In 2018, we described the practice of reviewing prisoners with prolific self-harming behaviour at the weekly safety intervention meeting (SIM) as an ‘impressive initiative’. Yet, at this review, these prisoners were no longer discussed at the SIM or at other regular meetings.

1.6 The lack of diligence and application by senior managers was exemplified by their poor response to our concerns over the use of special accommodation. Other than reminding staff to seek a governor’s approval before using it, no progress had been made since the inspection. This extreme custodial tool was still used far too often, for too long and with poor managerial oversight. The assurance we had been given at the inspection that the inappropriate practice of routinely removing a prisoner’s clothing on entering the cell would cease was not evident in the cases we reviewed.

1.7 Managers had reduced the use of illicit drugs. The percentage of prisoners failing random drug tests had fallen to an average of 15% in the previous six months. Less than 4% of prisoners had failed random drug tests in July 2019, which was an impressive figure.

1.8 The prison had acted to support inexperienced staff by restructuring its staffing model, improving training and introducing a buddy scheme. These actions were laudable but had yet to translate into a confident and authoritative staff group. We saw many examples of antisocial behaviour going unchallenged by staff.

1.9 The problems with the living conditions identified at previous inspections remained. We found dirty communal areas, food left out overnight and biohazard waste left beside a walkway. Many showers remained in very poor condition, and were some of the worst in the prison estate. The prison had refurbished a few to a high standard, only to find that they were incompatible with the prison’s water supply. We were told that future funding to refurbish showers had been withdrawn.

1.10 Disappointingly for a training prison, managers had made insufficient progress in improving purposeful activities. There were not enough activity spaces for the population, and too many prisoners remained unemployed or underemployed. Attendance at activities was poor, and those who did go to work and education classes often arrived late.

1.11 Managers had made good progress in protecting the public. Monthly public protection meetings were now well attended, and multi-agency public protection levels were confirmed in advance of prisoners’ release. While still not enough to meet the needs of the population, more places were available on the four accredited offending behaviour programmes than at the time of the inspection. Two non-accredited programmes had also been introduced.

1.12 However, managers had made insufficient progress in other areas of rehabilitation and release planning. As at the time of the inspection, about three-quarters of the population did not have an up-to-date assessment of their risk and need. Despite the promise of additional staff, the offender management unit (OMU) lacked the human resources to manage the population adequately. There was now a policy and action plan to manage prisoners
convicted of sexual offences but there were no accredited offending behaviour programmes to address their needs. We found a single offender supervisor managing 170 prisoners convicted of sexual offences, which was simply unworkable. Until recently, the strategic management of reducing reoffending had been neglected. Managers had, however, completed a reducing reoffending needs analysis a few days before our visit but it had not yet informed their strategy or action plan.

1.13 Overall, this was a disappointing review, and too little progress had been made in the nine months since the inspection. Managers had, in our view, failed to act with sufficient diligence and rigour concerning the key recommendations we made in 2018. There were signs that when managers focused on a problem, they could make good progress, as their work on drugs and public protection showed. The challenge is to replicate this progress on other key recommendations. We therefore echo our concluding remarks following the 2018 inspection: managers need to step back, reflect on our recommendations and act to achieve them with focus and determination.

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons

October 2019
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.

Encouraging positive behaviour

**Concern:** Levels of violence were high and had increased considerably since the previous inspection. Prisoner-on-prisoner assaults were high. In our survey, more than a third of prisoners said they currently felt unsafe. The approach to managing safer custody was not sufficiently strategic. Managers from key areas around the prison, such as health care, security and the OMU, were not fully engaged in managing the published violence reduction strategy.

**Main recommendation:** Prisoners should be and feel safe. The management of violence reduction should include input from all relevant agencies; be informed by accurate data; include prompt and robust investigations; and draw existing initiatives together in a coherent way. (S39)

2.1 The number of violent incidents during the previous six months was similar to that at the last inspection, and remained high. The number of assaults on prisoners indicated a marginal downward trend, but assaults on staff were increasing.

2.2 Attendance by relevant agencies at the monthly safer custody meeting had improved, but the committee did not analyse data in sufficient detail to gain a grasp on the issues and causes of violence impacting the prison. There was also no violence reduction strategy or action plan to draw existing initiatives together. We were shown a safer custody improvement action plan which contained some high-level statements of intent, but it was not detailed, meaningful or tailored to the specific causes of violence at the establishment.

2.3 Supervising officers and custodial managers, but not prison officers, had received training on how to use challenge, support and intervention plans (CSIPs). However, CSIP processes were still not fully embedded. The safer custody team did not assess whether all violent incidents were suitable for CSIP; at the start of September 2019, 33 violent incidents had yet to be assessed by the team. Too many investigations into violent incidents were insufficiently thorough or timely. Eleven prisoners were on a CSIP at the time of the review, but the plans we examined were not individualised or kept up to date.

2.4 The weekly multidisciplinary SIM identified and discussed individuals who posed a risk to others. It was reasonably well attended but often cancelled. The discussion on prisoners subject to a CSIP had improved.

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

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6 CSIPs are a case management system used to manage the most violent prisoners and support the most vulnerable. Prisoners who are the perpetrators of serious or repeated violence, or who are the victims of violence or bullying behaviour, are managed and supported on a plan with individualised targets and regular reviews.
Use of force

**Concern:** The governance of the special accommodation was poor and we were not confident that its use was always properly authorised or justified. The practice of routinely stripping prisoners of their clothing when entering the cell was poor.

**Recommendation:** Special accommodation should only be used in extreme circumstances and as a last resort. It should always be properly authorised and justified, and prisoners should be returned to normal conditions as soon as possible. The practice of routinely stripping prisoners of their clothing should cease.

2.6 Use of special accommodation continued to be very high, and was much higher than in similar prisons. In the previous six months, it had been used on 40 occasions, the same as in the six months prior to the inspection. Records did not satisfy us that this extreme custodial intervention was used as a last resort or always justified. Prisoners remained in special accommodation for too long – an average of six hours in the previous six months. In one case, it was decided at 4pm that a prisoner would remain in special accommodation overnight. This was inappropriate because the use of special accommodation must be reviewed at least hourly, to ensure that its continued use is for the minimum amount of time necessary.

2.7 All prisoners were strip-searched on arrival and placed into either prison clothes or strip-clothing. Segregation staff confirmed that it was usually the latter, and we saw anti-ligature strip-gowns laid out in the two special cells.

2.8 The special cells had been used inappropriately to hold prisoners who were at risk of self-harm. Such cells do not provide a supportive environment for prisoners in crisis.

2.9 Overall, managerial oversight of the use of special accommodation remained poor. Managers only discussed its use at quarterly meetings, which was too infrequent and not in accordance with Prison Service Instructions. Moreover, even those discussions only referred to the number of times the accommodation had been used, rather than to learn lessons or meaningfully assess practice. However, managers had sent a notice to staff, reminding them that the use of special accommodation should be authorised by a governor.

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

Security

**Concern:** The use of illicit drugs remained a serious problem for the prison, and in our survey 45% of respondents said that it was easy to get drugs. The average mandatory drug testing positive rate for 2018 was high, at about 25%. Drug reduction strategies were very new. Although initiatives to reduce drug use were helpful, some had not yet been fully embedded. Suspicion drug testing had stalled.

**Recommendation:** The supply of illicit drugs should be greatly reduced. The drug strategy should be fully embedded and senior managers should monitor its efficacy over time.

2.11 The positive random drug testing rate had reduced from 25% in the six months before the inspection to around 15% in a similar period before this review. During July 2019, it was at an impressive 3.5%. Suspicion testing had restarted and was more frequent, and there were now dedicated staff to carry out these tests.
2.12 The drug strategy was well embedded, and supported by an action plan which was monitored regularly at the drug strategy meetings. Working relationships between departments in the prison were good. A wide range of actions had been taken to address drug supply and demand. The security department shared intelligence on drug supply. A detector was now used to find illicit substances on incoming mail. Good cooperation with the police had resulted in some successful finds, arrests and prosecutions of visitors and staff. There had been some work to improve the physical security of the prison, and further approved plans were in place.

2.13 Partnership working with the substance use service provider, Forward Trust, was proactive. A range of services was available to prisoners, and voluntary drug testing had just been implemented for prisoners recovering from addiction.

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

Suicide and self-harm prevention

Concern: The monthly safer custody meetings did not always take place or drive improvement. The safer custody policy did not focus on the specific challenges at Swaleside and was not supported by a strategy or up-to-date action plan.

Recommendation: Strategic action to prevent suicide and self-harm should address the specific needs of Swaleside prisoners, take account of local trend analysis and be monitored over time against an up-to-date action plan. (1.51)

2.15 Since the inspection, there had been one suspected self-inflicted death. Levels of self-harm were similar to those at the time of the inspection. There remained a lack of strategic direction and initiative, and no action plan to help support the reduction of self-harm. Attendance at the safer custody meetings was better but they were still not driving improvement. Local data were analysed at the meeting but more in-depth analysis was needed to understand fully the causes of self-harm. The needs of prisoners with serious and prolific self-harming behaviour were no longer discussed at the safety interventions meeting, which we had described in our 2018 inspection report as an ‘impressive initiative’.

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

Staff-prisoner relationships

Concern: Thirty-five per cent of staff working on the residential units had been in post for less than 12 months, and this inexperience was often noticeable. Staff sometimes lacked the confidence to challenge poor behaviour or encourage prisoners to engage with the regime.

Recommendation: There should be visible leadership on the wings, to support inexperienced staff and model appropriate standards. (2.4)

2.17 The prison had restructured its managerial group, to increase the visibility and engagement of managers of all grades on the residential units. Additional custodial managers and supervising officers (SOs) had been introduced to residential staffing groups, and the residential managers had moved their offices out of the administration area and onto the wings.
Section 2. Progress against the key concerns and recommendations and Ofsted themes

2.18 Training for first-line managers had helped them to understand their roles in supporting and developing staff. SOs were now on duty on all wings during the working day, to oversee wing activities and support staff.

2.19 A buddy scheme had been introduced for newly trained staff, whereby they spent their first two weeks shadowing an experienced officer. A useful staff handbook, tailored to the establishment, complemented training information.

2.20 Despite these positive changes, it remained the case that not all staff were confident and authoritative in their dealings with prisoners. We continued to see antisocial behaviour going unchallenged by staff. For example, we saw racist graffiti (see photographs in Appendix II), prisoners disregarding wing rules, and prisoners loitering on walkways and delaying their return to residential units, all of which went unchallenged.

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

Living conditions

Concern: The older residential units were in poor condition, with dirty communal areas and serveries left uncleaned after mealtimes. Vermin were a problem, and rubbish was left overnight in corridors. Too many showers were in a poor state or out of use completely, and toilets were often inadequately screened and badly stained.

Recommendation: Prisoners should be provided with decent and respectful living conditions. (2.12)

2.22 As at the time of the inspection, there were more than enough cleaners and they should have ensured that residential units were maintained to an acceptable standard. However, communal areas remained grubby and cleaning schedules not adhered to. Cells were generally in a better state, although toilets continued to be poorly screened and often badly stained. Most food serveries were usually cleaned after service, but we found some to be dirty and to have the food trays from the previous day still left unwashed. We also saw food waste in bags left unattended for long periods in and around some serveries. Concerningly, we saw biohazard waste left for several days adjacent to a communal walkway.

2.23 The lack of clean working showers continued to be a serious problem for many prisoners. On some of the newer residential units, too many showers were out of action and had been waiting for repair for some time. Many showers on the older units were in a dreadful state: they were damp, mouldy and poorly ventilated. Despite the age and poor design, it was unacceptable that they also remained litter-strewn and dirty. Some showers had been refurbished to an excellent standard but were not used because they were incompatible with the prison’s water supply. We were told that funding for further refurbishment had been withdrawn (see photographs in Appendix II).

2.24 Managers had recently acted to address these problems. They had commissioned repairs, trained staff, introduced cleaning officers and conducted quality checks. However, these actions were in their early stages of implementation and had yet to improve living conditions.

2.25 We considered that the prison had made insufficient progress against this recommendation.
Time out of cell

2.26 Concern: Not enough prisoners were purposefully active. In our roll checks, almost a third of prisoners were locked in their cells. Attendance at education, training and work was too low. Prisoners regularly arrived at activities late and finished them early. Prison managers and wing officers did not ensure that prisoners attended education, training and work. Many prisoners were employed as cleaners, yet they did little work, and communal areas were dirty. This lack of purposeful activity undermined many other aspects of prison life, including rehabilitation.

Main recommendation: Prisoners should spend sufficient time out of their cells and engage in activities that support their rehabilitation. Attendance and punctuality in education, training and work should significantly improve so that they are good. (S41)

2.27 There were insufficient opportunities for prisoners to engage in work or training activities, with around 200 prisoners unemployed – far too many for a training prison.

2.28 In our roll checks, 38% of prisoners were locked in their cells during the working day – more than the 33% we had found at the inspection. The regime allowed for some time out of cell for these prisoners, but this consisted of time for showers, exercise and collecting meals, rather than working, studying or training.

2.29 Attendance at work and training remained poor, at around 60%, and far too often prisoners arrived late, and sessions terminated early. We saw prisoners go to the gym, library or to reception to collect property, rather than going to their scheduled training, work or education classes. These interruptions undermined the acquisition of good working habits (see Ofsted themes 1, 2 and 3).

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

Education, skills and work activities

Theme 1: What progress have leaders and managers made with their strategies to ensure that the process of allocations maximises the use of activity spaces and prioritises prisoners’ development of English and mathematical skills, ensuring that the education, skills and work needs of different groups of prisoners are met, and that they can access a suitable range of accredited and non-accredited qualifications?

2.31 Senior leaders and managers had not taken urgent enough action to rectify the main recommendations for improvement since the inspection. As a result, there had been negligible progress in increasing the number of activity spaces available to prisoners, improving the effectiveness of the allocations process and ensuring that prisoners attended activities on time.

2.32 Recent changes to the management of, level of staffing in and procedures associated with the prison’s activity hub had not yet resulted in prisoners being allocated to activities that met their needs or the objectives set out in their sentence plans, including the need to prioritise their English and mathematical skills. The prison’s labour board, which brought together relevant partners to decide on the most appropriate allocation for each prisoner, based on their sentence plan and career aspiration, was only reinstated during the review, having been

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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.
suspended for over nine months owing to a backlog of prisoner risk assessments. The new education subcontractor had very recently been given control of allocations to education courses. There were early signs that this had made the number of prisoners on English and mathematics courses more viable.

2.33 The number of activity spaces remained insufficient to meet the needs of the prison population. As a result, the number of unemployed prisoners continued to be unacceptably high. The proportion of prisoners left on the wings during the working day who were not engaged in learning, work and skills had increased since the inspection.

2.34 A small number of vulnerable prisoners were now able to access work in industries, and there had been a slight increase in the number of accredited vocational qualifications available to prisoners attending education courses. Leaders and managers had plans to increase the volume and breadth of vocational qualifications and places in industrial workshops, such as the manufacture of replacement doors, but these had taken too long to be implemented.

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

Theme 2: What progress have leaders and managers made in ensuring that prisoners develop an effective range of employment-related skills throughout the provision of education, skills and work?

2.36 Leaders and managers had taken no meaningful actions to develop a work ethic among prisoners since the inspection. Too few prisoners attended scheduled purposeful activities. As a result, not enough prisoners developed an effective range of employment-related skills.

2.37 Too many activity sessions started late and finished early. This was largely the result of morning and afternoon movements taking place in three stages, to keep prisoners apart. This led to too many activity sessions starting up to an hour later than scheduled. Opportunities for prisoners to develop an appropriate range of employment skills were therefore severely curtailed. The problem was further exacerbated by the practice of wing officers moving prisoners back to their cells up to half an hour before they were scheduled to finish their session. Education managers had recently appointed a student recruitment officer to monitor allocation to and attendance at education classes, but it was too soon to judge the impact of this new role.

2.38 Purposeful activity sessions were too often disrupted by a range of partner agencies deciding to schedule prisoners to attend legal, medical, religious or therapeutic treatment appointments during the working day. Leaders and managers exerted no central control over the scheduling of these interventions, by prioritising the importance of education, skills and work. As a result, prisoners routinely left activity sessions to attend, for example, a medical appointment, and then failed to return to the session afterwards.

2.39 Prisoners who attended activities regularly developed a suitable range of skills. Since the inspection, leaders had introduced a vocational qualification in food preparation at level 1 for prisoners working in the kitchen. A new multi-skills workshop offered prisoners an opportunity to study for a qualification and learn basic trade skills such as painting and decorating. However, no accreditation was available in the prison’s two commercial contract workshops.

2.40 Ofsted considered that the prison had made insufficient progress against this theme.
Theme 3: What progress have leaders and managers made in ensuring that they identify and monitor the quality of progress made by prisoners who are not undertaking an accredited qualification, and in raising the achievement rates in English, mathematics, and information and communications technology courses?

2.41 At the time of the inspection, managers had introduced a ‘portfolio of progress’ document, which was designed to recognise and record the achievement of prisoners in areas where qualifications were not available. However, it was not sufficiently used across all the different activities. This limited managers’ ability to judge prisoners’ progress in training and workshops where accreditation was not available. By the time of the review, the use of the portfolio of progress document had been discontinued. It was due to be replaced by a revised and suitably detailed progress document, designed by the industries manager. This was to be completed by prisoners across all prison work areas, to record the technical, personal and social skills they had developed as a result of participating in prison work. However, this progress document was yet to be implemented. As a result, current prisoners were not able to demonstrate the skills, knowledge and behaviour that they had developed in workshops and industries.

2.42 There were no validated data on prisoners’ achievement of qualifications from 2018/19, as the previous education provider had not made this information available to the new provider after the contracts for prison education had been awarded. As a result, it was not possible to assess whether achievement rates in English, mathematics, and information and communications technology (ICT) had improved since the inspection. Almost all prisoners who had enrolled on English, mathematics and ICT courses since the start of the new contract had stayed on their courses. However, overall attendance at English and mathematics classes remained too low, so prisoners’ progress in developing these skills was impeded.

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

Reducing risk, rehabilitation and progression

Concern: Not enough was done to rehabilitate prisoners. Too many prisoners did not have an up-to-date offender assessment system (OASys) assessment. There were not enough offender supervisors to ensure that the complex and sophisticated population progressed through long sentences and reduced their risk. Levels of contact between offender supervisors and prisoners were poor.

Main recommendation: Prisoners should be helped to reduce their likelihood of reoffending, and their risk of harm should be managed effectively. Prisoners should have regular contact with an offender supervisor and an up-to-date OASys document to help them address their offending behaviour and ensure their progression is monitored effectively. (S42)

2.44 Some efforts had been made to reduce the OASys assessment backlog for high-risk prisoners but too many prisoners, about 74%, did not have an up-to-date assessment of their risk and need, which was similar to the percentage at the time of the inspection. Eleven per cent of these had no initial OASys assessment (see also paragraph 2.65), and about 62% had not been reviewed in the last 12 months. The prison was responsible for most of these cases. This was having an impact on the prison’s ability to reduce these prisoners’ risks.

8 OASys is a system used by offender managers to assess how likely a prisoner is to reoffend and the seriousness of harm should the prisoner reoffend. OASys identifies prisoners’ offending related needs and informs a plan to manage the risks presented by the prisoner.
2.45 Positively, prison offender supervisors’ time was now mainly protected, and not lost to other prison duties. However, as at the time of the inspection, there were only 3.2 full-time-equivalent (FTE) probation officers and 6.5 FTE offender supervisors to manage over 1,000 prisoners. Staffing levels in the OMU were chronically under-resourced, and insufficient to manage the complex and high-risk population effectively.

2.46 Recruitment had started for additional probation and prison offender managers, in anticipation of the new Offender Management in Custody model, which was to go live in December 2019.

2.47 Probation staff had caseloads of about 45–50 prisoners, comprising high-risk and complex prisoners. The average caseload for prison offender supervisors was 100, which was too high to enable meaningful contact. For example, one offender supervisor was managing 170 prisoners convicted of sexual offences, which was unmanageable (see also paragraph 2.51).

2.48 Contact with offender supervisors was still mainly reactive. It was not uncommon for prisoners to go for several months, if not more than a year, without any contact with their offender supervisor. The lack of structured one-to-one interventions did not drive prisoners’ sentence progression.

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

**Concern:** A cohort of prisoners convicted of a sexual offence, with outstanding treatment needs, had been introduced since the previous inspection. They did not receive adequate offender management and there were no programmes available to enable them to reduce their risk of harm or progress.

**Main recommendation:** HMPPS and the prison should develop a strategy that reduces the level of harm presented by prisoners convicted of a sexual offence; progresses them through their sentence; and protects the public during custody and on release. (S43)

2.50 About 16% of the population was convicted of sexual offences, which was about the same as at the time of the inspection. The prison had recently developed a policy and action plan to address the challenges of managing this population but plans were in their infancy and had not been agreed or published.

2.51 There was only one offender supervisor to manage these prisoners (see also paragraph 2.47), and few structured one-to-one interventions took place to motivate and progress them through their sentence. There were still no specific accredited offending behaviour programmes available to enable these prisoners to reduce their risk of harm, and there were no plans to introduce any (see also paragraph 2.66).

2.52 Efforts to ascertain exact levels of unmet need and suitability for programmes had only just started. The OMU had started to identify how many prisoners required a Risk Matrix 2000 assessment to inform their treatment pathway needs. Two members of staff had been trained to carry out these assessments. The intention was then to progress prisoners with unmet treatment needs to other establishments to access appropriate programmes.

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9 Offender Management in Custody is a model that is being implemented in two stages. The first stage, involving the introduction of key workers, has largely been implemented. The second stage aims to improve offender management in prisons by introducing prison offender managers and employ more probation officers in prisons.

10 Risk Matrix 2000 is a tool used to assess the risk posed by adult male prisoners convicted of a sexual offence. It uses a range of static factors to indicate the likelihood of future offending.
2.53  Most prisoners convicted of sexual offences were in denial of their offence. Some could now access two non-accredited programmes: Motivation and engagement, and Foundation (see also paragraph 2.66). This was a positive development but there were not enough places to meet the need, and the number of prisoners completing these courses was low.

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

Concern: The strategic management of reducing reoffending was weak, and undermined by frequent changes in departmental leadership. Reducing reoffending meetings lacked a clear agenda, were poorly attended and did not drive improvement. The reducing reoffending strategy was very new and did not highlight the specific challenges faced by the prison or identify the key priorities for change. There was no reducing reoffending action plan to expedite progress.

Recommendation: Work to reduce reoffending should be informed by a needs analysis based on an accurate, up-to-date range of data. Progress should be routinely measured against an action plan by senior managers. (4.21)

2.55  The prison had done some work to understand prisoners’ needs, with a useful analysis of these needs completed a few days before our review visit, using prisoner survey results, and criminogenic and demographic information. Work was still needed to incorporate these findings into a new reducing reoffending strategy and action plan, to reflect current need and set up-to-date strategic priorities to drive outcomes for prisoners.

2.56  Until recently, the overall strategic management of reducing reoffending had been neglected. Meetings had not consistently and effectively identified priorities, reviewed progress or driven improvements, and since the inspection there had been a gap of nearly five months when meetings had not taken place at all.

2.57  Work to reduce reoffending had not been given sufficient priority, and the lack of wider prison involvement was apparent. However, early signs of progress were encouraging. A new head of reducing reoffending had recently taken up post, meetings had been reinstated and priorities to drive improvements for prisoners were understood.

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

Public protection

Concern: Public protection work was weak. Monthly public protection meetings were inconsistent and rarely attended by offender supervisors, which hindered their effectiveness. High-risk prisoners were not always considered, and multi-agency public protection arrangements (MAPPA) management levels for those due for release were not always confirmed.

Recommendation: Monthly public protection meetings should routinely consider all high-risk prisoners and those due for release who will potentially be subject to multi-agency public protection arrangements (MAPPA) arrangements in the community. MAPPA management levels should be confirmed far enough ahead of release to ensure that effective supervision arrangements can be implemented. (4.26)

2.59  The establishment continued to hold a large proportion of prisoners, about 72%, assessed as presenting a high risk of harm, and about the same percentage who were eligible for MAPPA on release.
2.60 We found that public protection meetings were now effective. Two separate monthly interdepartmental risk management team meetings consistently took place: one focused on prisoners convicted of sexual offences, and the other on the general population. Chaired by the senior probation officer, these meetings were well structured, focused and appropriately attended by offender supervisors and wider prison staff. They routinely considered all high-risk prisoners on arrival and those approaching release, to ensure that their risks were managed appropriately.

2.61 Levels of contact between community offender managers and OMU staff were good. MAPPA management levels were confirmed far enough ahead of a prisoner’s release to ensure that arrangements were efficient.

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

Interventions

Concern: There were too few places on offending behaviour programmes to meet the needs of the population, and none specifically for prisoners convicted of sexual offences.

Recommendation: There should be enough places on accredited offending behaviour programmes to meet the needs of the population. (4.38)

2.63 The prison continued to run four accredited offending behaviour programmes: the thinking skills programme (TSP), Resolve (a moderate-intensity programme to reduce violence), Kaizen (a general anti-violence programme) and Kaizen IPV (a programme to address intimate partner violence).

2.64 There were more places available on these courses than at the time of the inspection (up from 58 to 81 places), and the prison had more than doubled the number of places on the TSP in response to need (from 18 to 45 places). However, there were still not enough to meet the known needs of the population. For example, 45 places were available on the TSP for the year, with a waiting list of those assessed and suitable of 105. There were 18 places on Resolve, with a waiting list of 80. Over the year, 10 places were available for the Kaizen programme, with 47 on the waiting list.

2.65 In addition, there was a cohort of unknown need. The lack of up-to-date OASys assessments, particularly for the 11% of prisoners without an initial assessment (see also paragraph 2.44) and sentence plan, was having an impact on the prison’s ability to understand the true extent of need.

2.66 The introduction of the Foundation non-accredited programme, delivered exclusively for prisoners convicted of sexual offences (see also paragraph 2.53), was positive but there were still no accredited offending behaviour programmes for these prisoners (see also paragraph 2.51).

2.67 We considered that the prison had made reasonable progress against this recommendation.
## Section 3. Appendices

### Appendix I: Review team

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tbody>
<tr>
<td>Martin Lomas</td>
<td>Deputy Chief Inspector</td>
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<tr>
<td>Colin Carroll</td>
<td>Team leader</td>
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<tr>
<td>Natalie Heeks</td>
<td>Inspector</td>
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<tr>
<td>Jade Richards</td>
<td>Inspector</td>
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<tr>
<td>Paul Rowlands</td>
<td>Inspector</td>
</tr>
<tr>
<td>Charles Searle</td>
<td>Ofsted inspector</td>
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<tr>
<td>Jai Sharda</td>
<td>Ofsted inspector</td>
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</tbody>
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Appendix II: Photographs

Racist graffiti on cell door

Old shower
New shower, which was incompatible with the prison water system and therefore not working