Report on an independent review of progress at

# HMP Lewes

by HM Chief Inspector of Prisons

**2–4 December 2019**

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



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

Printed and published by:
Her Majesty's Inspectorate of Prisons
3rd floor
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London
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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 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 January 2019 for further detail on the original findings.[2]

# IRP methodology

A6 IRPs will be announced at least three months in advance and will take place eight to 12 months after the full inspection. When we announce an IRP, we will identify which recommendations we intend to follow up (usually no more than 15). Depending on the recommendations to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

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

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

2 https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/hmp-lewes-2/.

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 or 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.

[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 12 of the 53 recommendations made at our most recent inspection and made judgements about the degree of progress achieved to date. Ofsted followed up three themes.

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

**Figure 1: Progress on recommendations from 2019 inspection (n=12)[4]**

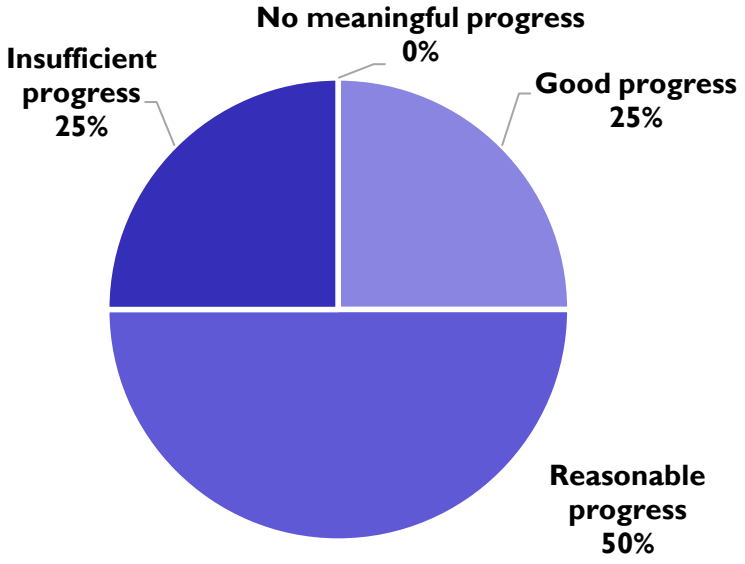



**Figure 2: Judgements against HMI Prisons recommendations from 2019 inspection**

| Recommendation | Judgement |
|---|---|
| The prison should develop a comprehensive violence reduction action plan, which is driven forward by a sufficiently resourced safer custody team and regularly monitored to establish its effectiveness. (S39) | Reasonable progress |
| The prison should implement a strategy to reduce self-harm, which is based on a robust analysis of self-harm data and delivers consistently good care for prisoners at risk of self-harm through multidisciplinary assessment, care in custody and teamwork (ACCT) case management. (S40) | Reasonable progress |
| Health governance structures should be robust enough to identify and effectively address key risks and concerns and should ensure that prisoners have prompt access to all health services. (S41) | Reasonable progress |
| There should be a prison-wide approach to offender management, based on a robust needs analysis. It should include effective joint working and information exchange, a common approach to record-keeping, and a detailed strategy for managing the large number of sex offenders. (S43) | 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.

| | |
|---|---|
| Rigorous governance of use of force should ensure that documentation is completed promptly and thoroughly, and that all planned incidents are recorded. (1.27) | Good progress |
| Measures to identify and control drug supply, including suspicion testing and use of technology, should be implemented systematically. (1.43) | Reasonable progress |
| Managers should ensure that staff actively support prisoners and challenge poor behaviour. (2.3) | Insufficient progress |
| Cells, wings and outside areas should be kept clean. (2.10) | Reasonable progress |
| All health care staff should receive regular clinical and managerial supervision and be up to date with mandatory training. (2.52) | Good progress |
| Prisoners with long-term health conditions should receive regular reviews by trained staff, informed by an evidence-based care plan. (2.70) | Insufficient progress |
| Prisoners referred to the service should be reviewed and assessed promptly and offered a suitable range of mental health interventions within agreed timescales. (2.86) | Good progress |
| All eligible prisoners should have an up-to-date OASys assessment. Offender management should proactively engage prisoners and focus on progression and the reduction of risk of harm. (4.15) | Insufficient progress |

S3 Ofsted judged that there was reasonable progress in one theme and insufficient progress in two themes. The was significant progress in none of the themes.

**Figure 3: Progress on Ofsted themes from 2019 inspection (n=3)**

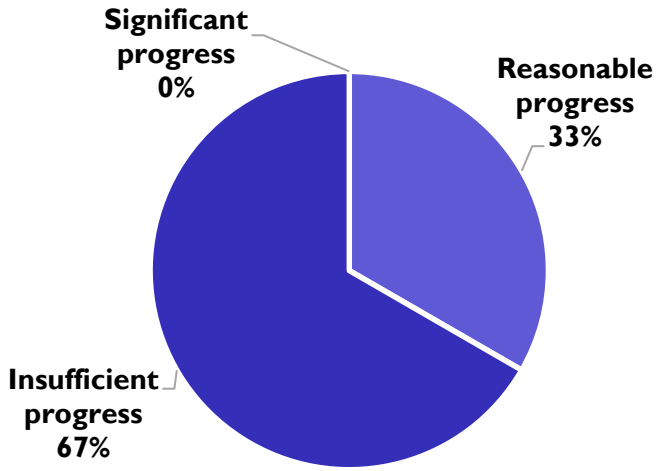



**Figure 4: Judgements against Ofsted themes[5] from 2019 inspection**

| Ofsted theme | Judgement |
|---|---|
| What progress have leaders and managers made with their strategies to improve the provision of education, skills and work, ensuring that all prisoners are adequately allocated to activities, enabling them to participate in training and qualifications that increase their chances of employability on release? | Insufficient |
| What progress have leaders and managers made in improving the quality of teaching, learning and assessment for all groups of learners, ensuring that teachers plan learning to enable prisoners to make good progress, using good learning resources and developing prisoners' English and mathematics skills? | Reasonable |

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

| | |
|---|---|
| What progress have leaders and managers made in securing good quality work provision that enables prisoners to develop a work ethic and in ensuring that a high number of prisoners complete their qualifications and achieve well? | Insufficient |

# Section 1. Chief Inspector's summary

**1.1** At our inspection of HMP Lewes in 2019 we made the following judgements about outcomes for prisoners.

**Figure 5: HMP Lewes healthy prison outcomes 2015 and 2019.**


**1.2** HMP Lewes in East Sussex is a medium-sized category B local prison. Its main function is to serve the local courts by holding unsentenced and newly sentenced prisoners. The average length of stay is short at about nine weeks. In addition to this core function, the prison holds recalled prisoners and those with a variety of sentence lengths, including lifers and those convicted of sexual offences. Like many other local prisons, it dates from the Victorian era and much of its infrastructure is old and cramped.

**1.3** When we inspected the prison in January 2019, it had been in 'special measures' for two years, but outcomes for prisoners were declining rather than improving. A great deal of urgent work was needed to improve safety. The number of assaults against staff was high, a fifth of all assaults were serious and a quarter of prisoners said they felt unsafe. Despite this, the prison lacked an effective strategy for reducing violence. Force was used frequently, but its oversight was poor, and far too much paperwork justifying its use was missing. Illicit drugs were a big security problem, yet the prison had not done enough to identify or control their supply. Self-harm was common and five prisoners had taken their own lives between our 2016 and 2019 inspections. Again, the prison lacked an adequate strategic response to this problem. Many prisoners reported that staff treated them with respect, but a number of officers lacked authority and were too passive in their interactions with prisoners. Cleanliness on wings was generally poor and there were rats and large amounts of bird droppings in outside areas. We found very real weaknesses in the leadership and management of health services. These deficiencies meant our colleagues in the Care Quality Commission issued requirement notices relating to three breaches of the commission's regulations. Mental health services, nurse-led primary care and care for prisoners with long-term conditions were poor. Ofsted judged the overall effectiveness of education, skills and work provision as inadequate, its lowest score. Teaching and prisoners' learning were not good enough. Too many prisoners were unemployed, with only enough activity places for two-thirds of the population. Prison managers were aware of these problems but did not have a clear strategy for improving learning and skills. Not enough was done to reduce the

risks of prisoners reoffending after release. More than 100 assessments of prisoners' risks were out of date or had not been completed. Prison departments did not work closely to reduce prisoners' risks and had not adequately analysed the population's needs. As in many other areas of the prison, there was no overarching strategy for driving improvement in this area.

**1.4** During this independent review of progress, we found a prison with a renewed sense of purpose and direction. The prison had been taken out of special measures and had discarded the associated bureaucracy and ineffective action plan. The governor and her senior managers understood our concerns and recommendations, and had formulated a more realistic and focused plan for improvement. We were pleased to find that the prison had made good or reasonably good progress in two-thirds of the areas that we reviewed during this visit.

**1.5** The prison had consulted staff and prisoners about what was causing violence in the prison. This consultation had informed a revised safety strategy and action plan. The safer custody team was now better resourced. However, these positive developments had yet to translate into reduced levels of violence. There were in fact now more assaults against staff than at the time of the inspection.

**1.6** Managers now had much better oversight of the use of force than at the inspection. Nearly all planned incidents were video-recorded and the amount of outstanding paperwork justifying the use of force had been greatly reduced.

**1.7** The number of prisoners testing positive in random drug tests had fallen. Prison staff were making much better use of technology and search dogs to disrupt the supply of drugs. However, staff were still not carrying out enough targeted drug tests following the receipt of intelligence.

**1.8** The number of self-harm incidents in the previous six months had declined by over a third compared to a similar period before the inspection. One prisoner had taken their own life following our inspection. Managers had used an analysis of self-harm data to inform a new comprehensive strategy but had yet to publish it. Despite regular quality assurance, assessment, care in custody and team work documentation for those at risk of suicide or self-harm required improvement.

**1.9** Managers assertively challenged prisoners' antisocial behaviour, but officers' approaches were not always consistent. Despite this, officers were generally supportive of prisoners in their care.

**1.10** Managers now paid more attention to cleanliness and hygiene, and overall standards had improved. The problem with rats had been tackled. Offensive displays were no longer visible and graffiti had been reduced. Despite these improvements, some showers were run down and dirty, while many communal areas remained untidy.

**1.11** Health governance structures had improved, and health care staff now received clinical and managerial supervision. Care for prisoners with long-term health conditions had also improved but was undermined by the large number of prisoners who did not attend their appointments. The mental health service was better than at the inspection, and more interventions were available.

**1.12** There were still insufficient activity places for the population and some prisoners remained unemployed for more than two months. Officers did not routinely challenge prisoners who chose not to attend an activity. The overall quality of teaching, learning and assessment had improved. Prisoners could now study short modules in English and mathematics, which were

better suited to the prison with its high turnover of prisoners. However, not enough prisoners benefited from work-related qualifications.

**1.13** The prison had published an offender management strategy and established a committee to improve joint working and information sharing between departments involved in prisoners' rehabilitation. The prison held fewer registered sex offenders than before and had implemented a sensible strategy for managing the population and ensuring prisoners progressed to a more suitable prison.

**1.14** The number of prisoners without an offender assessment system (OASys) report had been reduced, but the prison could not tell us how many OASys assessments needed to be reviewed. While some offender management unit staff had frequent, good quality contact with prisoners on their caseload, others did not. Proactive interactions with prisoners were hampered by staff shortages and a lack of suitable interview rooms.

**1.15** Overall, this was a promising review. The governor and her senior managers were taking the prison in the right direction. They were realistic about the scale of the challenges they faced and understood that further progress would require sustained effort and vigour. Their challenge now is to build on the progress they have made since the inspection and to translate this work into positive outcomes for prisoners. Nevertheless, they should be congratulated on what they have achieved so far.

**Peter Clarke CVO OBE QPM** December 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 2019. The reference numbers at the end of each recommendation refer to the paragraph location in the full inspection report.

## Encouraging positive behaviour

**Concern:** Nearly a fifth of all assaults were serious and the number of assaults against staff had nearly doubled. The prison did not yet have an effective strategic response to violence. The safer custody team was under-resourced and there was insufficient follow up of concerns identified at safer custody meetings. The management of perpetrators of violence and support for victims were weak. Too many violent incident investigations were incomplete, and there was no violence reduction action plan.

**Recommendation: The prison should develop a comprehensive violence reduction action plan, which is driven forward by a sufficiently resourced safer custody team and regularly monitored to establish its effectiveness.** (S39)

**2.1** Managers had carried out a wide range of consultation with prisoners and staff, along with some good data analysis, which had informed a new safety strategy and violence reduction action plan. The action plan, implemented in September 2019, was comprehensive and sought to manage the main drivers of violence. It was reviewed regularly at the well-attended safer custody meeting and action was robustly managed.

**2.2** The safer custody team was now better resourced than at the inspection. A supervising officer had been appointed to work full time in the team and two officers based in residential units supported the team. All incidents of violence were now thoroughly investigated.

**2.3** These improvements had yet to translate into better outcomes for prisoners. The number of assaults on prisoners had remained constant since our inspection, and the number of assaults on staff had increased slightly.

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

## Use of force

**Concern:** Monthly use of force meetings were often poorly attended and generated insufficient action. Use of force paperwork was outstanding in 18% of all incidents in the previous six months. None of the records we viewed included an 'injury to prisoner' form. Not all planned use of force was video-recorded and we were only able to observe footage from approximately half of relevant cases.

**Recommendation: Rigorous governance of use of force should ensure that documentation is completed promptly and thoroughly, and that all planned incidents are recorded.** (1.27)

**2.5** Rigorous and effective governance of the use of force was now in place, which ensured that most documentation was completed promptly and thoroughly. Every week, use of force

instructors and senior managers reviewed incidents, trends, concerns, training issues and outstanding paperwork. A monthly meeting was held to analyse data and follow up on incomplete or missing paperwork.

**2.6** At the inspection, there were 121 pieces of outstanding paperwork; at this review there were 36, a substantial reduction. 'Injury to prisoner' forms were now completed for most incidents.

**2.7** The prison now had enough hand-held cameras and only one planned incident had not been video-recorded since the inspection. The use of force committee reviewed all available footage once a month.

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

## Security

**Concern:** Drugs were a key security threat, with drugs thrown over the prison walls contributing to the problem. The prison had taken measures, such as installing overhead netting on exercise yards, but the two x-ray machines used to detect drugs did not work and had been out of service for a considerable time. Equipment to detect drugs on incoming post was not yet in use. In our survey, almost half of prisoners said it was easy to get illegal drugs in HMP Lewes.

**Recommendation: Measures to identify and control drug supply, including suspicion testing and use of technology, should be implemented systematically.** (1.43)

**2.9** Much better use was now being made of technology to detect drugs, although the equipment had only just begun to be used effectively. All property entering the prison was now screened using x-ray machines. Reception staff had x-rayed 268 items of property since October 2019 and removed eight items. Since June 2019, the prison had used an itemiser to detect mail containing drugs. The itemiser was only operating at about 80% capacity due to staffing shortages and a lack of trained staff.

**2.10** Metal detectors and a body orifice security scanner were used to intercept illicit items. Unlike at some other prisons, a body scanner was not used. This might have improved the security of the prison and prevented more illicit items entering the prison. Three drug dogs were now available, compared to only one at the time of the inspection. They were used to search visitors, cells, communal areas and post.

**2.11** Local corruption prevention measures were reducing the number of illicit items entering the prison. Two significant smuggling routes into the prison had been disrupted since the inspection.

**2.12** The number of prisoners testing positive in random drug tests had fallen. In the six months before the inspection in January 2019, the positive random mandatory drug testing rate averaged 22%. This figured had now fallen to about 16% in the previous six months. However, the prison was still not conducting enough suspicion drug tests following the receipt of intelligence. Between April and October 2019, managers had requested 49 tests, yet only four were completed.

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

## Suicide and self-harm prevention

**Concern:** Levels of self-harm were high and there had been five self-inflicted deaths since the previous inspection. Despite this, there was no clear strategy, based on a robust analysis of data, to reduce self-harm. The quality of case management documentation remained poor and lacked sufficient health care input.

**Recommendation: The prison should implement a strategy to reduce self-harm, which is based on a robust analysis of self-harm data and delivers consistently good care for prisoners at risk of self-harm through multidisciplinary assessment, care in custody and teamwork (ACCT) case management.** (S40)

**2.14** The number of self-harm incidents had declined by over a third in the previous six months compared to a similar period before the inspection (195 compared to more than 324). There had been one self-inflicted death since the inspection. Managers had analysed local self-harm data and written a comprehensive self-harm prevention strategy but had yet to publish it. Plans were in place to implement the new strategy early in 2020 following final consultation with prisoners and staff. The safer custody team analysed a wide range of self-harm data and implemented action from the analysis.

**2.15** ACCT procedures for prisoners at risk of suicide or self-harm were now regularly quality assured but still required improvement. Case notes still lacked sufficient detail and, while health care staff attendance had improved, not all case reviews were sufficiently multidisciplinary.

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

## Staff-prisoner relationships

**Concern:** We did not observe any derogatory conduct by staff towards prisoners, but their approach was too passive and poor behaviour often went unchallenged, including obvious drug use and prisoners refusing to attend work or education. Some keyworker entries on P-Nomis (a database used in prisons for the management of offenders) were reasonable, but others demonstrated that the officer was not actively helping the prisoner to address issues raised.

**Recommendation: Managers should ensure that staff actively support prisoners and challenge poor behaviour.** (2.3)

**2.17** To provide greater support for wing staff at critical times, custody managers were now more visible on wings during unlocking and locking up times. Verbal daily briefings had been introduced to emphasise that staff should support and challenge prisoners. These messages were reinforced at the monthly training sessions.

**2.18** In theory, officers used a helpful monitoring process to identify why prisoners were refusing to attend work or education. In practice, the documentation was not being completed as required.

**2.19** Managers challenged low-level poor behaviour effectively and assertively, but officers did not consistently challenge poor behaviour. For example, we saw prisoners vaping and wearing inappropriate clothing on landings.

**2.20** The roll out of the keyworker scheme had been inhibited by staff shortages and it was only being promoted on M wing. Despite this, prisoners we spoke to and records we checked, reflected that staff were generally supportive of prisoners in their care.

**2.21** The proportion of officers with less than two years' experience had declined from 70% to 40%. Officers we spoke to had mixed views about the amount of help and support they received from managers. Some felt extremely well supported while others did not, in almost equal measure.

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

## Living conditions

**Concern:** Cleanliness was generally poor on the older wings (A and C), where floors and ceilings had ingrained dirt. Outside areas were generally clean, but we saw rats during our visit and a large amount of bird droppings on outside buildings. Cells varied in condition but needed redecoration, and many contained abusive graffiti. Recent efforts to repaint cells had been long overdue.

**Recommendation: Cells, wings and outside areas should be kept clean.** (2.10)

**2.23** Cleanliness and hygiene had been given a higher priority. Senior managers now assumed direct oversight and carried out cell checks every fortnight. Fortnightly meetings with works staff had been introduced to ensure that problems with shortages of equipment or materials were addressed more efficiently. Cleaning schedules and job descriptions for cleaners had also been reviewed and improvements had been made where possible. A daily briefing had been introduced for staff to reinforce the importance of maintaining a clean and decent living and working environment.

**2.24** Painting and decorating had been carried out across the prison since the inspection, not all of which was completed to a good standard. Funding had been obtained to deep clean all cell toilets and a major refurbishment of the showers on K and A wings was due to be carried out imminently. The best living conditions were on L wing, where cells and communal areas were decorated, furnished and maintained to a good standard. The poorest conditions were on A and C wings, where some of the showers were rundown and dirty. Elsewhere, standards of hygiene and cleanliness were variable. While many communal areas remained untidy, overall standards of cleanliness had improved since the inspection and there was less ingrained dirt. (See Appendix II: Photographs.)

**2.25** Graffiti had been reduced significantly, and offensive displays were no longer evident. With the help of professional support and feral cats, the rodent problem had been tackled successfully and there was less rubbish in outside areas.

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

## Health, well-being and social care

**Concern:** Health governance structures did not effectively address risks and concerns such as the under-resourced mental health services, long waiting lists and the very poorly managed health care applications process; we found large numbers of applications that had received no action, entailing significant risks to prisoner well-being.

**Recommendation: Health governance structures should be robust enough to identify and effectively address key risks and concerns and should ensure that prisoners have prompt access to all health services.** (S41)

**2.27** There was now an agreed robust governance structure for health services. Partnership and local delivery board meetings were in place and the terms of reference had been reviewed and ratified.

**2.28** Sussex Partnership NHS Trust had implemented a weekly local team meeting, which monitored progress on required improvements. Applications were now managed more promptly and there were regular audits to monitor the 24-hour response target.

**2.29** Senior oversight of identified service risks on the risk register was not robust. The action and mitigation had not been effective, and some risks remained unresolved for more than a year. Some of the long-term unresolved risks included: prisoners not getting to their health appointments; too few rooms to deliver clinics; and the lack of two-way radios to keep health staff safe.

**2.30** Waiting times had improved but were exacerbated by the large number of prisoners who did not attend their appointments. The figure for those not attending their appointments was reported to delivery and partnership board meetings, but no progress had been made on this issue. We witnessed two clinics with zero attendance because prisoners were attending other activities, there were wing restrictions or prison officers failed to bring prisoners to the health care department.

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

**Concern:** There had been 16 deaths since our previous inspection, five of which were self-inflicted. Not all the health-specific Prisons and Probation Ombudsman (PPO) recommendations from reports into these deaths had been achieved. Of most concern was the number of clinicians with out-of-date life support training and the lack of input into ACCT reviews. The provision and uptake of clinical and managerial supervision was not consistent across the teams.

**Recommendation: All health care staff should receive regular clinical and managerial supervision, and be up to date with mandatory training.** (2.52)

**2.32** Training plans for all Sussex Partnership Trust health care staff were now in place and monitored every week. Any action arising from weekly monitoring was allocated to clinical lead staff to progress.

**2.33** Managerial supervision and reflective practice for all Sussex Partnership Trust staff were now embedded and monitored weekly. Most staff felt supported and were participating in reflective practice opportunities (which encourages health care professionals to reflect on their actions to identify areas for continuous learning and development).

**2.34** All Sussex Partnership Trust clinical staff had undertaken basic or immediate life support (ILS) courses and plans were in place to upgrade all clinical staff to ILS training.

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

**Concern:** The overall management of long-term conditions was poor, and patients did not have care plans to inform their ongoing care. Management was GP-led and ad hoc. There were no regular specialist nurse-led clinics.

**Recommendation: Prisoners with long-term health conditions should receive regular reviews by trained staff, informed by an evidence-based care plan.** (2.70)

**2.36** A new long-term conditions process and patient pathway had been implemented. All those identified were now on a patient register. The registers were monitored every week and all those on the register who had not had a comprehensive review had a scheduled

appointment. Prisoners who were classed as non-attenders, either because they chose not to attend or, more frequently, because officers were unable to transfer prisoners to the health care department from the wing or activities, were rebooked several times. There were plans to visit patients on the wings after they had failed to attend several appointments to check their potential engagement in the next appointment.

**2.37** A long-term conditions nurse attended the prison to support the assessment and care planning of those on the register and to offer the nursing team additional supervision. Those who had been seen and assessed now had meaningful care and treatment plans.

**2.38** Appointments were booked promptly, but the lack of access to health care created longer waiting times and a significant loss of clinical resources. Some prisoners remained unmonitored, lacked care plans and did not have regular reviews due to the lack of access. We saw two long-term conditions clinics with zero attendance and 15 missed appointments in two days. In November 2019, 10 long-term conditions clinics were booked with a total of 219 appointments. Of these, 125 appointments were missed.

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

**Concern:** There was a high level of mental health need in the prison. During the inspection, there were 71 patients on the open referrals list, some of whom had been waiting for up to four months. Those we looked at had been triaged via their case notes, but if this did not trigger a high enough priority, they risked being left on the open referrals list and could deteriorate without the mental health team being aware. Patients were prioritised according to risk, and those of most concern were discussed at a weekly referrals meeting. During the inspection, 44 patients had been assessed as requiring intervention. Over half were waiting to see the psychiatrist, with the longest wait at four months. The service had deteriorated since our previous inspection. Staffing vacancies, coupled with the high number of referrals, meant that the team struggled to meet patients' mental health needs promptly.

**Recommendation: Prisoners referred to the service should be reviewed and assessed promptly, and offered a suitable range of mental health interventions within agreed timescales.** (2.86)

**2.40** The mental health service had improved and effective clinical oversight had been introduced. Staffing levels had also improved. An additional specialist registrar was in place to support the consultant psychiatrist and waiting times for a medical consultation were shorter and were now four to six weeks.

**2.41** There was now a clear referral pathway for mental health services. Those who were at a potentially higher risk to themselves or others due to their presentation were managed as a priority.

**2.42** Referrals were dealt with every day by a member of the clinical mental health team and allocated to appropriate individual staff at a weekly meeting for ongoing care, and care plans were in place for those on the caseload. More mental health interventions were available than at the inspection.

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

# Education, skills and work[6]

**Theme 1: What progress have leaders and managers made with their strategies to improve the provision of education, skills and work, ensuring that all prisoners are adequately allocated to activities, enabling them to participate in training and qualifications that increase their chances of employability on release?**

**2.44** Prison leaders and managers had worked hard to establish meaningful activities to improve the learning and skills provision. They actively promoted education and training to prisoners as part of their progress towards successful rehabilitation and resettlement into the community. The governor was very supportive of action to improve the education and vocational training programmes. Leaders and managers had a good understanding of their strengths and weaknesses. Allocations staff had developed new approaches to ensuring that prisoners were allocated promptly to activities, but it was too early to assess the impact of these changes.

**2.45** After a long period without any formal contract, prison leaders had commissioned a company to provide prisoners with careers information, advice and guidance. As a result, prisoners received clear guidance on how they could use their time in custody productively to improve their prospects of resettlement. Where appropriate, staff linked resettlement plans to sentence plans well.

**2.46** There were still insufficient activity places for the population and too many prisoners were unemployed for more than two months. Wing managers did not make sure that all prisoners allocated to an activity were unlocked and those choosing not to attend were not routinely challenged.

**2.47** Managers had begun to use staff training days each month to talk to prisoners and encourage them to enrol on an education or training course. This had resulted in an increase in the number of prisoners expressing an interest in attending education or training, although the overall number of prisoners participating in purposeful activity was still too low.

**2.48** Prison managers recognised that the quality improvement group did not adequately oversee the quality of education and training. Plans were in place to improve monitoring and the process for challenging education and training managers.

**2.49** Ofsted considered the prison had made insufficient progress against this theme.

**Theme 2: What progress have leaders and managers made in improving the quality of teaching, learning and assessment for all groups of learners, ensuring that teachers plan learning to enable prisoners to make good progress, using good learning resources and developing prisoners' English and mathematics skills?**

**2.50** The overall quality of teaching, learning and assessment had improved since the inspection. Staff planned learning sessions well, using individual learning plans effectively to develop suitable activities that enabled prisoners to build confidently on previous learning. Most prisoners were motivated to learn and enjoyed their time in education or vocational training sessions. Staff used trained peer mentors well to help prisoners in learning sessions understand difficult concepts.

**2.51** Prison and college managers had worked well together to increase the range of provision. Staff provided effective non-accredited programmes in art, music and creative writing to help

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

engage prisoners in education and to support their English and mathematics skills development. A significant minority of prisoners progressed from entry level English and mathematics to at least level 1.

**2.52** Staff provided a small number of prisoners who were in work areas with good support to develop their English and mathematics skills and, as a result, they achieved qualifications and progressed onto further study. Managers had successfully developed a range of short units in English and mathematics, which met the needs of those in the prison for a short time and many prisoners completed these short unit courses successfully. Several moved on to achieve full qualifications in functional skills in English and mathematics. The proportion of prisoners gaining a qualification, particularly in English and mathematics, had improved significantly and was good. Managers prevented prisoners from moving to another prison while they completed their education and training, which had improved prisoners' achievement of qualifications.

**2.53** Attendance at educational and vocational training had slightly increased since the inspection to approximately 60%, although it needed to improve further. Punctuality was reasonably good for those unlocked and able to attend. Prison managers ensured that education and vocational training classes remained open when there was a shortage of operational prison staff.

**2.54** Ofsted considered the prison had made reasonable progress against this theme.

**Theme 3: What progress have leaders and managers made in securing good quality work provision that enables prisoners to develop a work ethic and in ensuring that a high number of prisoners complete their qualifications and achieve well?**

**2.55** The learning, skills and work provision had undergone a period of significant instability. Staff had been reallocated and transferred from other prisons to maintain the existing provision. Many staff were on sickness absence, had been suspended or had resigned. During the visit, there was no head of industries.

**2.56** Not enough prisoners benefited from work-related qualifications. At the inspection, prison managers had recognised the missed opportunity to provide qualifications for prisoners working in the kitchens. At this review, prisoners did not have adequate time to study and there were no qualified assessors to support the delivery and accreditation of qualifications in the kitchen.

**2.57** A security operation had found that significant illicit items were being smuggled through the workshop. This resulted in its temporary closure and had limited the range of work and vocational training. The provision offered multi-skills training in construction, food hygiene courses, barista and hospitality training. Managers had introduced cleaning and recycling training courses and there were plans to increase the range of vocational training to include areas such as horticulture.

**2.58** Managers had introduced a Passport to Employment for prisoners in prison jobs, which was used to record prisoners' attitudes, 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** Ofsted considered the prison had made insufficient progress against this theme.

# Reducing risk, rehabilitation and progression

**Concern:** The strategic management of rehabilitation work was weak. Prison departments did not work closely to reduce the risk of reoffending. Offender management unit staff did not record all contact they had with prisoners on P-Nomis case notes, which undermined coordinated working. The criminogenic factors in the population had not been addressed. A large number of sex offenders were held yet there was no detailed strategy to reduce their risks.

**Recommendation: There should be a prison-wide approach to offender management, based on a robust needs analysis. It should include effective joint working and information exchange, a common approach to record-keeping, and a detailed strategy for managing the large number of sex offenders.** (S43)

**2.60** The prison had published an offender management strategy, but it had not been applied in full. Despite this, some good work had started. An offender management strategic committee had been established, met monthly and was comprised of key managers involved in prisoner rehabilitation. This new committee had only met twice, but early signs showed that some promising action was being drawn up during the meetings, including the potential for more effective joint working and better information exchange. Some offender management unit (OMU) staff were making better use of P-Nomis case notes to record their work. The prison had implemented a partner pre-release panel, an inter-departmental meeting comprised of managers from key departments, such as health care, resettlement and the OMU. The panel monitored the resettlement needs of all prisoners due for release in the following 12 weeks. The panel had only met three times, but it was a promising initiative.

**2.61** A senior manager had conducted a reducing reoffending needs analysis that involved consultation with prisoners. The analysis was helpful and assisted the prison in planning the courses they would provide in the new financial year.

**2.62** At the inspection the prison held 85 registered sex offenders. By the time of this review, the number had been reduced to 61. The prison had implemented a sensible strategy for managing the sex offender population. It involved assessing the risks presented by those convicted of sexual offences and planning their progress to prisons that could provide suitable courses. In the previous six months, 46 prisoners convicted of sexual offences had been moved.

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

**Concern:** Too many OASys reports were incomplete or late. At the start of our inspection, 64 prisoners had not been assessed who should have been. A further 59 prisoners who had been assessed now had out-of-date assessments. The OMU attempted to prioritise potential high-risk cases but this did not obviate the risks of having so many prisoners without an up-to-date assessment. The quality of OASys reports and sentence plan objectives was variable. There were no minimum requirements for contact between the offender supervisors, probation officers and prisoners, and OMU staff contact with prisoners was insufficient and reactive. Many prisoners had no contact with the OMU and others were only seen at trigger points, such as before parole hearings. This meant that offender supervisors did not follow up sentence plan targets to ensure that they were met.

**Recommendation: All eligible prisoners should have an up-to-date OASys assessment. Offender management should proactively engage prisoners and focus on progression and the reduction of risk of harm.** (4.15)

**2.64** The number of prisoners without an OASys assessment had declined from 64 at the inspection to 34 at this review. Offender management staff did not review prisoners' OASys

report every year and could not provide us with the number of prisoners whose OASys reviews were overdue. We found one prisoner's review was overdue by almost three years, which was unacceptable. Prisoners told us that the lack of prompt assessments left them frustrated. Despite regular quality assurance of OASys, the standard of assessments remained inconsistent.

**2.65** The quality and frequency of contact between OMU staff and prisoners was variable. While some OMU staff updated prisoners regularly and in person, this was not consistent. Some prisoners told us that they had not had any contact with the OMU and others said they did not know who their prison offender manager was. Prison offender managers struggled to see prisoners on their caseload due to shortages of staff. They remained hampered by a lack of suitable interview rooms where they could meet and interact with prisoners.

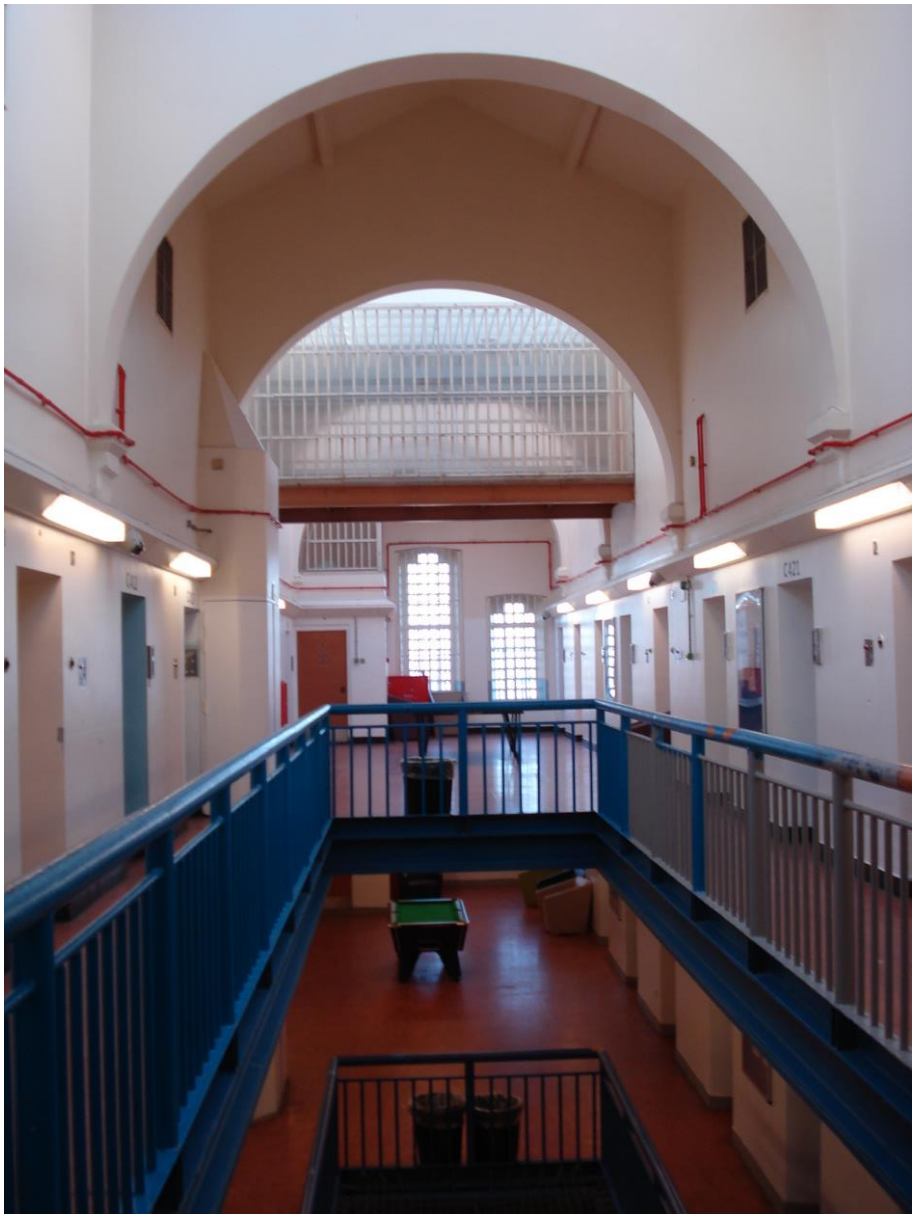
**2.66** We considered that the prison had made insufficient progress against this recommendation.

# Section 3. Appendices

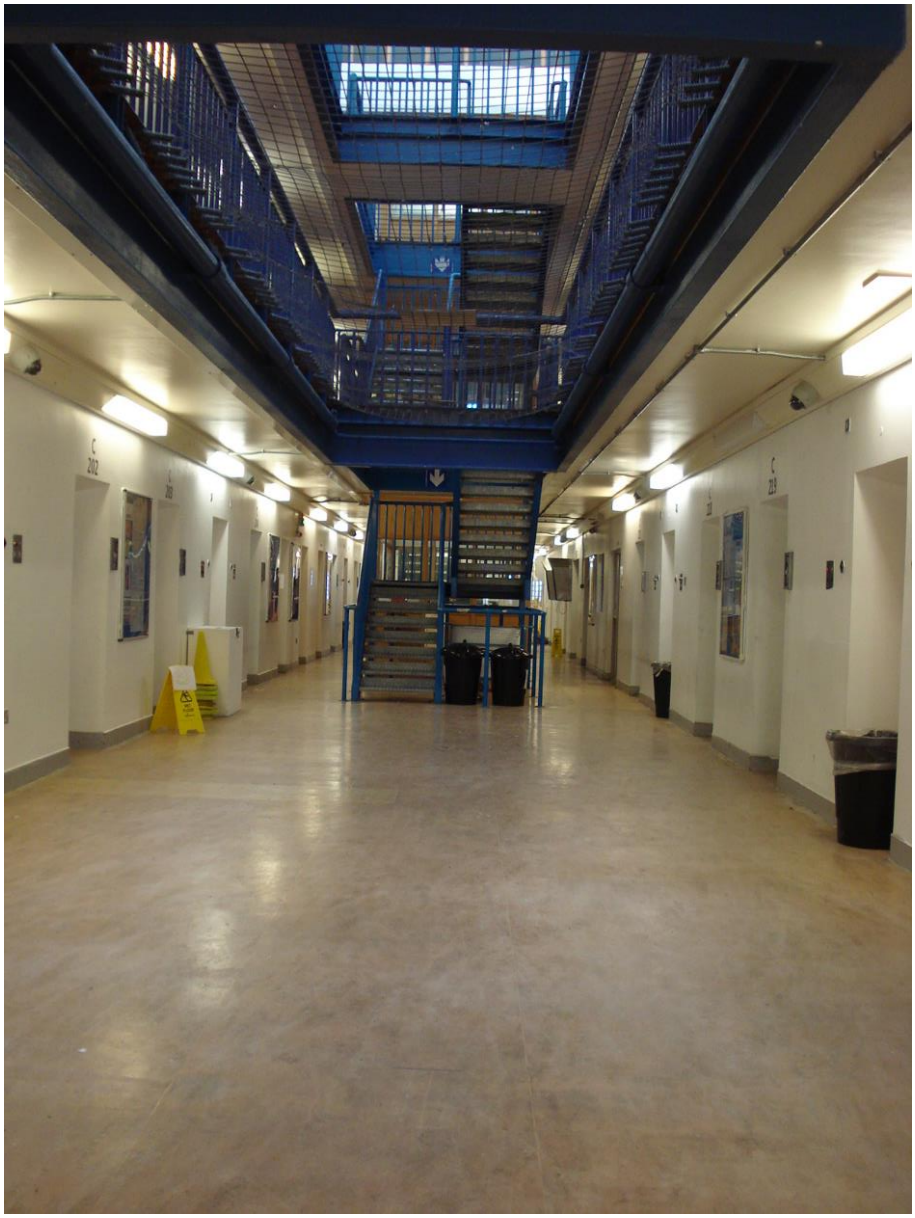
## Appendix I: Review team

| | |
|---|---|
| Peter Clarke | Chief Inspector |
| Colin Carroll | Team leader |
| Ian MacFadyen | Inspector |
| Esra Sari | Inspector |
| Darren Wilkinson | Inspector |
| Tania Osborne | Health services inspector |
| Bob Cowdrey | Ofsted lead inspector |
| Dave Baber | Ofsted inspector |
| Monserrat Perez | Ofsted inspector |

# Appendix II: Photographs



'C' wing



Residential unit

Damaged tiling in wing laundry room

Showers

Outside area