

Report on an independent review of progress at

HMP Pentonville

by HM Chief Inspector of Prisons

4–6 February 2020

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Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain any terms you find labelled with an asterisk in this report. If need an explanation on any other terms, please see the longer glossary in our 'Guide for writing inspection reports', available on our website at: <http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/>

Challenge, support and intervention plan (CSIP)

CSIPs are used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Some prisons also use the CSIP framework to support victims of violence.

Key work

Introduced under the offender management in custody (OMiC) model, prison officer key workers aim to have regular contact with named prisoners.

Urgent Notification

Where HM Chief Inspector of Prisons identifies significant concerns on the treatment and conditions of those detained in prisons, he may write to the Secretary of State within seven calendar days of the end of the inspection, providing notification of the significant concerns and the reasons for those concerns. See: <https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/urgent-notifications/>

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. 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/hmiprison/our-expectations/>
- 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 April 2019 for further detail on the original findings: <https://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2019/08/Pentonville-Web-2019.pdf>

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.

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

No meaningful progress

Managers had not yet formulated, resourced or begun to implement a realistic improvement plan for this recommendation.

Insufficient progress

Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken since our inspection had not yet resulted in sufficient evidence of progress (for example, better and embedded systems and processes).

Reasonable progress

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

Good progress

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

- A9 When Ofsted attends an IRP its methodology will replicate the monitoring visits conducted in further education and skills provision. 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>. Each theme followed up by Ofsted will be given one of three progress judgements.

Insufficient progress

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

Reasonable progress

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

Significant progress

Progress has been rapid and is already having considerable beneficial impact on learners.

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

Key findings

- S1 At this IRP visit, we followed up 15 of the 39 recommendations from our most recent inspection and Ofsted followed up three themes.
- S2 HMI Prisons judged that there was good progress in one recommendation, reasonable progress in three recommendations, insufficient progress in five recommendations and no meaningful progress in six recommendations. A summary of the judgements is as follows.

Figure 1: Progress on HMI Prisons recommendations from 2019 inspection (n=15). This pie chart excludes any recommendations that were followed up as part of a theme within Ofsted's concurrent prison monitoring visit.

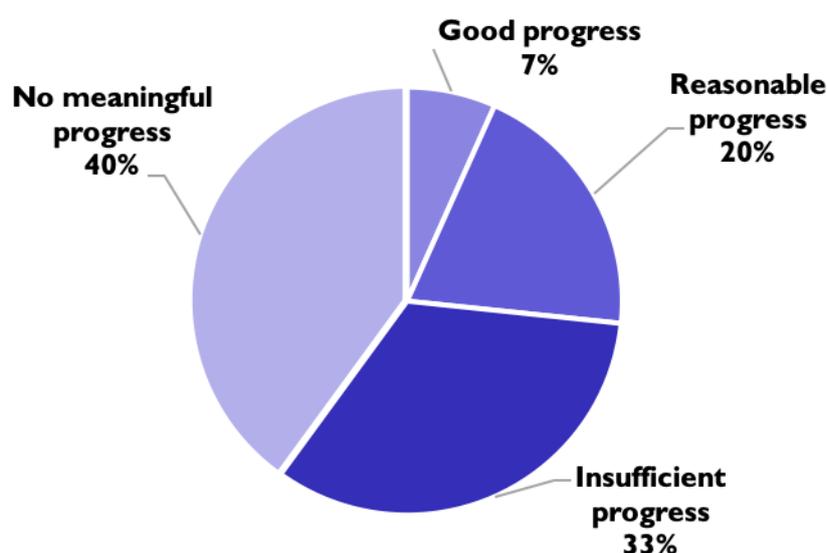


Figure 2: Judgements against HMI Prisons recommendations from 2019 inspection

| Recommendation | Judgement |
|--|------------------------|
| A suitably resourced safer custody team should work proactively and collaboratively with other departments in the prison to reduce levels of violence. This violence reduction work should include prompt investigations into incidents of violence and suitable interventions to manage perpetrators and support victims. (S47) | No meaningful progress |
| Managers should ensure that regular and effective scrutiny is undertaken of key safety processes, including violence reduction, segregation, adjudications and use of force. This should be underpinned by the review of routinely collected reliable and comprehensive data. (S48) | Insufficient progress |
| Use of force should be accountable. Use of force documentation, video footage and incidents involving use of batons should be routinely reviewed and lessons learned; this should be overseen by regular and well attended use of force meetings. (S49) | No meaningful progress |
| Prisons and Probation Ombudsman recommendations should be fully implemented and subject to continuing and repeated reinforcement. (S50) | No meaningful progress |
| Robust management of ACCTs should include consistent case managers who take ownership of cases and provide continuity of care, multidisciplinary reviews and a robust quality assurance process. (S51) | No meaningful progress |
| The prison should implement a supply reduction strategy, which is | Good progress |

| | |
|--|------------------------|
| overseen by a multidisciplinary team at regular meetings. Action planning should ensure that all facets of the strategy, such as intelligence-led drugs testing, are carried out efficiently. (S52) | |
| Physical security should be enhanced through the prompt replacement of windows and installation of CCTV coverage where necessary. (S53) | Reasonable progress |
| Managers should ensure that staff behave respectfully towards prisoners, actively supporting them and challenging poor behaviour, in line with the principles of a rehabilitative culture. (S54) | Insufficient progress |
| Cells should provide decent and hygienic conditions, including properly screened toilets and sufficient space for each occupant. (S55) | Insufficient progress |
| The new equality strategy should cover all protected groups and be overseen by regular equality meetings to ensure effective implementation. It should include actions in relation to effective consultation, analysis of monitoring data and prompt response to diversity complaints. (S56) | No meaningful progress |
| The prison health care local delivery board should ensure that assertive action is taken to enable access to health care, safe storage of in-possession medicines, and a prison-wide strategy for health and well-being. (S57) | Reasonable progress. |
| Managers should ensure that all prisoners have the opportunity to participate in a full and purposeful regime and are encouraged to attend activities. (S58) | No meaningful progress |
| All relevant departments and agencies should play a full part in strategic and risk management work, including relevant meetings. (S60) | Insufficient progress |
| All prisoners should have an up-to-date OASys assessment. (S61) | Reasonable progress |
| The CRC should ensure that all eligible prisoners receive an initial resettlement plan which is reviewed before their release. (S62) | Insufficient progress |

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

Figure 3: Progress on Ofsted themes from 2019 inspection (n=3). This pie chart excludes any recommendations that were followed up as part of a theme within Ofsted's concurrent prison monitoring visit.

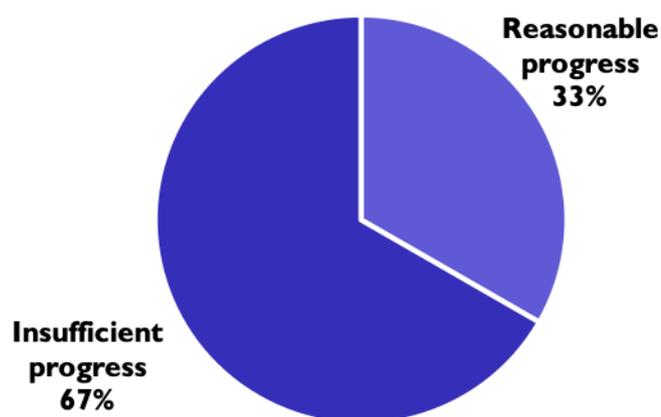


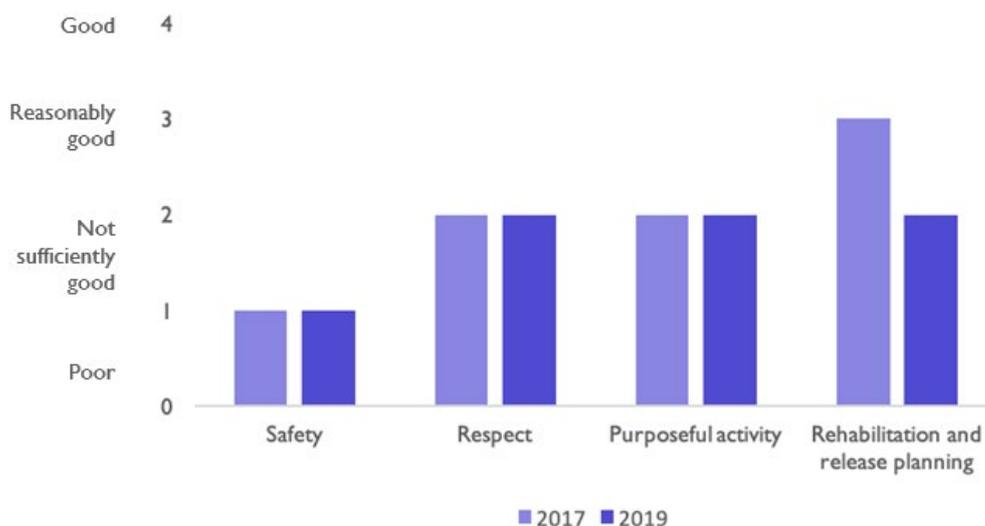
Figure 4: Judgements against Ofsted themes from 2019 inspection. Ofsted's themes incorporate the key concerns at the previous inspection in respect of education, skills and work.

| Ofsted theme | Judgement |
|--|-----------------------|
| What progress have leaders and managers made to improve the processes of induction and allocation to activities, ensuring that all men can access an appropriate range of education, skills and work activities, including vulnerable prisoners? | Insufficient progress |
| What progress have leaders and managers made in quality assuring and improving the quality of teaching, learning and assessment received by all prisoners, including those with learning difficulties, ensuring all prisoners attend education, skills and work activities well? | Reasonable progress |
| What progress have leaders and managers made in raising the achievement of prisoners undertaking English and mathematics qualifications at level 1, ensuring they use data well to monitor and secure good education, training and employment destinations for prisoners on release? | Insufficient progress |

Section 1. Chief Inspector's summary

- I.1** At our inspection of HMP Pentonville in 2019 we made the following judgements about outcomes for prisoners.

Figure 5: HMP Pentonville healthy prison outcomes 2017 and 2019.



- I.2** HMP Pentonville, an inner-city category B local male prison serving the London courts, is one of the oldest and most famous prisons in the country. It is a large, complex establishment with a transient population of more than 1,000 adult and young adult prisoners, ranging from those recently remanded to others serving significant sentences.
- I.3** We last inspected Pentonville in 2019 when we reported poor outcomes in our healthy prison test of safety, and not sufficiently good outcomes in the areas of respect, purposeful activity, and rehabilitation and release planning. At the time we highlighted a failure to meet the undoubted challenges faced by this prison, but were critical that only one of our 15 recommendations on safety had been achieved in full.
- I.4** At that last inspection, in April 2019, we reported that violence had increased significantly and that work to analyse and address this had been inadequate. There had been a sharp rise in the use of force, and there was no strategy to reduce the high levels of illicit drugs despite their ready availability throughout the prison. There had been four self-inflicted deaths in the two years between the 2017 and 2019 inspections. Despite this, the response to recommendations made by the Prisons and Probation Ombudsman following its investigations into the deaths had been inadequate, and case management support (assessment, care in custody and teamwork, ACCT) for prisoners in crisis was poor. Living conditions for many prisoners were also poor, and a negative attitude among certain staff indicated some deep-rooted cultural problems that got in the way of delivering positive work with prisoners. Nearly a third of prisoners were locked in their cells during the working day, and attendance at activities remained poor. Ofsted judged the overall effectiveness of education, skills and work across the prison as 'requires improvement'. The strategic approach to rehabilitation work remained weak, and prisoners did not receive enough support throughout their sentence.
- I.5** At the time of the 2019 inspection we gave serious consideration to invoking the inspectorate's Urgent Notification (UN) procedures*. Our decision not to follow this path

was based on us having some confidence in the plans proposed by an enthusiastic new senior management team. However, we were very clear that we would return within the year to conduct an independent review of the progress (IRP) being made against the key concerns and recommendations in the report.

- I.6** Unfortunately, our findings at the end of this IRP, more than nine months after the inspection, were a cause for continued concern. The prison had made good progress in only one of the 15 key concerns and recommendations, and reasonable progress against only a further three. There had been no meaningful progress against six key concerns and recommendations, and insufficient progress against the remaining five. This was the poorest progress that we have seen in any of the IRPs that we have conducted to date.
- I.7** We were joined during this IRP by our colleagues from Ofsted, who conducted a monitoring visit to follow up three themes drawn from recommendations on the education, skills and work provision at the prison. Managers had made reasonable progress against one of those themes and insufficient progress against the other two.
- I.8** The IRP revealed that in terms of safety, until very recently there had been a lack of clear accountability at every level. Action planning to deliver the safety strategies that were now in place had been neither swift nor effective. Indeed, overall levels of violence had once again increased. The key strategic safety meeting that should have been an effective vehicle for driving improvements was not used well for this purpose. Despite the high levels of violence, case management delivered through the challenge, support and intervention plans (CSIPs)* had not yet been implemented effectively. There were few incentives to motivate good behaviour, and too many adjudications for serious breaches of the rules were written off. This failure to grip and manage key processes created a culture where violence and poor behaviour could all too easily go unpunished.
- I.9** Data collection and analysis within the safety function were showing early signs of improvement, particularly in monitoring the use of segregation. Recently introduced quality assurance measures had the potential, if applied more robustly, to improve outcomes. However, scrutiny overall was still not rigorous, which resulted in the poor delivery of key safety processes. For example, scrutiny of the increasing use of force had only begun in earnest a few weeks before we returned to conduct this review, and managers could assure neither themselves nor us that all uses of force were justified.
- I.10** ACCT processes were not managed effectively, and quality assurance had only been introduced in the weeks before the review. Tragically, there had been three self-inflicted deaths in the nine months since our last inspection. These were currently under investigation by the Prisons and Probation Ombudsman (PPO). The response to the early learning points was weak, and implementation of recommendations from previous suicides could only be described as lacklustre. A failure to discuss actions at key strategic meetings, and an over-reliance on staff information notices, characterised the prison's approach to learning from deaths in custody.
- I.11** In contrast, the prison had made good progress in tackling its significant drug problem. There was now a coherent supply reduction strategy, with an action plan that was being driven through a well-attended multidisciplinary meeting. The number of prisoners testing positive for drugs, although still high, had reduced since our inspection in April 2019. Reasonable progress had also been made to improve physical security, but the prison needed ongoing funding to complete this work.
- I.12** We observed some very good interactions between staff and prisoners during our visit, but some prisoners reported that staff could be rude and unhelpful. Managers and staff did not set high standards for prisoners, and we witnessed some low-level bad behaviour that staff did not challenge. It was very disappointing that key work (in which prison officers have

regular contact with named individual prisoners) had stalled in August 2019 and had only just been revived in the weeks leading up to our review.

- I.13** The prison had clearly placed a greater focus on environmental cleanliness, which had improved, and cell repairs and refurbishment were under way. However, the pace of improvement was slow and there was still some way to go to establish and maintain decent living conditions. Equality work remained neglected. There had been reasonable progress in the area of prisoner health and well-being.
- I.14** Managers understood that boredom and inactivity contributed to bad behaviour, violence and poor well-being. Despite this, prisoners at Pentonville still spent far too long locked in their cells during the working day. Even though there were sufficient part-time activity spaces for the entire population, only just over two-thirds of the spaces were used, and over 300 prisoners were unemployed. Attendance by those who were allocated to an activity was often poor. To compound this, prisoners were given very little time out of their cell to shower, exercise and associate with their peers.
- I.15** Ofsted inspectors found that there had been insufficient progress in the allocation of prisoners to education, skills and work. A high number of prisoners allocated to education never started their courses, and a third of prisoners who did start their course did not complete it, which was much higher than at the inspection.
- I.16** The quality of teaching had improved, particularly for prisoners with learning difficulties or disabilities. However, too few prisoners gained qualifications in English and mathematics during their time at the jail.
- I.17** Work to reduce reoffending and prepare prisoners for release was slow to progress and had not been prioritised.
- I.18** I was so concerned by the findings of this IRP that immediately after it was concluded I wrote to the Secretary of State expressing my serious concern at the lack of progress since the last inspection. I was particularly disappointed to see that in many areas little or nothing had been done until very shortly before the IRP took place. I acknowledged that a change of leadership at the prison since the inspection had been problematic. I also made the point that lasting improvement would not be achieved through the simple expedient of reducing the prisoner population and giving more resources to the prison. The solution to most issues was in the gift of the prison, but would need a truly collaborative effort from all staff, clear leadership and support from Her Majesty's Prison and Probation Service (HMPPS).
- I.19** I also explained to the Secretary of State that I had decided not to invoke the UN procedure, but that the Inspectorate would return in November 2020 to conduct a further full inspection. This would give the prison and HMPPS a full nine months from the time of the IRP to act upon its findings and make Pentonville a safer, more decent, purposeful and rehabilitative establishment.

Peter Clarke CVO OBE QPM

HM Chief Inspector of Prisons

February 2020

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.

Managing behaviour

Concern: Levels of violence had increased significantly since our last inspection. The strategic management of violence was weak. Investigations were currently not being completed and a case management approach to managing perpetrators of violence and supporting victims was yet to be introduced.

Recommendation: A suitably resourced safer custody team should work proactively and collaboratively with other departments in the prison to reduce levels of violence. This violence reduction work should include prompt investigations into incidents of violence and suitable interventions to manage perpetrators and support victims. (S47)

- 2.1 At our inspection in April 2019 we reported high and increasing levels of violence. At this review we found that the overall level of violence had increased again, by approximately 10%. Assaults on staff had increased by over 30%. A small number of incidents were serious. Managers were not adequately sighted on this increase, which was concerning.
- 2.2 Despite some improvement in resources in the safer custody team, there remained important gaps that limited the range and quality of work delivered. For example, there was no trained analyst in post and, despite the prison's knowledge that debt played a significant role in violence, there were no plans to tackle this.
- 2.3 Not all incidents of violence were properly recorded. Following an incident, one member of the safer custody team had responsibility for seeing the perpetrators of violence and their victims. This approach was neither consistent, investigative in nature nor sufficiently robust. Consequently, the prison was unable to provide specific details of how many investigations had been completed and how many remained outstanding.
- 2.4 Recent safety forums, held separately with prisoners and staff, had led to a pertinent review of the prison's safety and violence reduction strategies. However, it was not always clear who was accountable for key elements of safety, and there was no up-to-date, time-bound action plan to drive and monitor implementation of the strategies. This had inevitably stalled progress in this important area.
- 2.5 Monthly strategic safety meetings, which should have been prioritised to drive improvements, did not always take place and representation from some key departments, including residence, was poor. Recently introduced weekly safety intervention meetings were promising, although important updates on prisoners of concerns, such as those on constant supervision, were not yet provided routinely.
- 2.6 The prison had implemented CSIP as a case management process for managing the perpetrators of violence and other antisocial behaviour, and supporting the victims of such incidents. It had been launched later than at other prisons, and the process was still not fully functioning as a tool to manage violence. Staff awareness of the process was limited, and

departments across the prison had made relatively few referrals to the safer custody team. Approximately half the total of 55 CSIP referrals made since it had been launched were by the safer custody team, and only a third were from residential officers.

- 2.7** None of the seven CSIP documents that were open during our visit contained an intervention plan, a core component of the process. Their value in helping prisoners to reduce their propensity to violence was negligible. Current support arrangements for victims of violence were inadequate, amounting to little more than a welfare check from safer custody staff and a possible wing move.
- 2.8** We considered that the prison had made no meaningful progress against this recommendation.

Concern: We found a concerning lack of rigour and management scrutiny across violence reduction work, segregation, adjudications and use of force. A lack of adequate data collection and analysis was symptomatic of this failure of process and meant that managers lacked the necessary information to assess effectiveness of practice, identify opportunities for improvement or identify weaknesses.

Recommendation: Managers should ensure that regular and effective scrutiny is undertaken of key safety processes, including violence reduction, segregation, adjudications and use of force. This should be underpinned by the review of routinely collected reliable and comprehensive data. (S48)

- 2.9** With the exception of use of force, data collation had generally improved. There was now a comprehensive but only recently introduced spreadsheet to collect relevant information on segregation use and adjudications. However, a variety of internal data on violence was gathered locally, which contradicted other official published data. The prison had yet to reconcile this effectively, which made it difficult for it to understand the true picture of violence.
- 2.10** In the previous two months, the segregation monitoring and adjudications standardisation meetings had started some good analysis of data. Attendance at the meetings was not consistent, and the useful analysis had not yet led to relevant action planning.
- 2.11** The adjudication backlog had reduced, although much of this had been achieved by writing off large numbers of serious charges. This undermined the effectiveness of the process to punish rule breaking and reduce violence. Furthermore, there was still no robust mechanism to track and advance charges that had been referred to the police to investigate, with the risk that the most serious offences would go unpunished.
- 2.12** The concept of motivating good behaviour was underdeveloped at Pentonville. There were few tangible incentives, and managers did not carry out the quality assurance needed to make the formal incentives and earned privileges (IEP) scheme effective. The number of prisoners on the basic level of the scheme bore little correlation to the number on CSIP, even though prison managers acknowledged that many prisoners were on the basic level due to their involvement in violence.
- 2.13** Managers had introduced some quality assurance processes, including for adjudications, segregation paperwork and the use of batons. However, assurance checks had not taken place in all relevant cases, and those that had sometimes failed to identify poor practice. It was unclear what lessons were learned following quality assurance, or how it was used to improve future practice.
- 2.14** We considered that the prison had made insufficient progress against this recommendation.

Concern: Use of force had increased significantly since our last inspection and was higher than comparator prisons. Managerial oversight was inadequate, with no routine scrutiny of use of force documentation or video footage. Batons had been drawn 14 times and the use of batons was not investigated.

Recommendation: Use of force should be accountable. Use of force documentation, video footage and incidents involving use of batons should be routinely reviewed and lessons learned; this should be overseen by regular and well attended use of force meetings. (S49)

- 2.15** We were only able to obtain figures on the use of force for the previous five months due to poor data collection, but its use in this period was already higher than in the six months before our inspection in April 2019. Governance of the use of force remained poor overall. There had been recent attempts to introduce more effective systems, although a new database contained some inaccurate information as it was updated from documents that were often completed inadequately.
- 2.16** Use of force documents were variable and generally lacked sufficient detail. This made it difficult to assess if force was always justified and if de-escalation was used effectively. In many of the cases we reviewed, the documents had still not been completed.
- 2.17** A weekly use of force scrutiny meeting to examine paperwork and CCTV footage of incidents had been introduced three weeks before this review. However, quality assurance remained weak. We were not assured that the prison routinely reviewed CCTV footage at these meetings. Managers could not provide us with a random sample of videos that we requested, even though use of force documentation said it was available. Prison officers did not routinely activate body-worn cameras during use of force incidents.
- 2.18** Although managers said they had started reviewing all cases of baton use, we found reviews for only five of the 11 incidents when a baton had been drawn in the previous six months. In one case where a baton had been used, the prison was unable to provide the details of this or documentation when we requested it. The reviews that had taken place lacked rigor and scrutiny.
- 2.19** The use of special accommodation had increased. In the cases we reviewed, the documentation did not provide sufficient justification for its use, and levels of observations set for officers were often insufficient. In one case, a prisoner on ACCT had been placed in special accommodation, but his safety screen was not conducted for nine hours, and there was no record that he had been observed during the night.
- 2.20** We considered that the prison had made no meaningful progress against this recommendation.

Safeguarding

Concern: There had been four self-inflicted deaths and one death from natural causes since the previous inspection. As at the last inspection, Prisons and Probation Ombudsman (PPO) recommendations were not systematically implemented.

Recommendation: Prisons and Probation Ombudsman recommendations should be fully implemented and subject to continuing and repeated reinforcement. (S50)

- 2.21** It was concerning that there had been three self-inflicted deaths in the nine months since our last inspection. The PPO was investigating these at the time of our review. The HMPPS

regional office had issued some early learning briefs in response, but these had not featured in any recorded discussions or meetings.

- 2.22** There was an action plan for PPO recommendations but this did not accurately reflect the position within the establishment. For example, the prison had identified that implementation of the CSIP process was needed to achieve a recommendation and this was marked as completed in October 2019, but CSIP was not implemented until two months later.
- 2.23** The responsible manager used the action plan to have discussions with other managers to monitor progress, but these meetings were not recorded and the action plan was not discussed in detail at any key meeting. Staff responsible for prisoners were not, therefore, aware of the recommendations and how they could contribute to their delivery. We were told that this would be on the agenda of the monthly safer custody meetings from February 2020.
- 2.24** There was an over-reliance on issuing notices to staff as a means of communicating PPO recommendations, with no follow-up action to check that staff had both read and understood the information. As a result, there had been no improvements or effective implementation. For example, ACCT processes remained weak (see below)
- 2.25** We considered that the prison had made no meaningful progress against this recommendation.

Concern: The management of ACCTs remained poor, with limited multidisciplinary involvement in reviews and inconsistent case management. Quality assurance was weak.

Recommendation: Robust management of ACCTs should include consistent case managers who take ownership of cases and provide continuity of care, multidisciplinary reviews and a robust quality assurance process. (S51)

- 2.26** Strategic oversight of prisoners in crisis, particularly those with complex needs, was too limited and, despite some very recent efforts, there had been no progress in improving the quality of ACCTs.
- 2.27** The sample of ACCTs we reviewed were poor. Care maps were often incomplete, and case reviews were not always prompt or multidisciplinary. Several case reviews had taken place with only the prisoner and a case manager in attendance, which limited the multidisciplinary approach to care that was needed. Most ACCTs had no consistent case manager and observational entries were limited. One ACCT we reviewed did not have the initial assessment and first case review for three days. We were told that there had been efforts to provide continuity of case managers, but this had only been introduced on one wing in the previous month and it was too early to judge its effectiveness. Single case management was due to be rolled out to the rest of the prison by March 2020, but more robust oversight was needed to deliver this effectively.
- 2.28** Quality assurance processes remained weak. A process for reviewing ACCT documentation had been introduced in the previous week and it was too early to assess its impact on improving quality.
- 2.29** We considered that the prison had made no meaningful progress against this recommendation.

Security

Concern: Drug availability was high and 29% of prisoners had tested positive in random drug tests in the last six months. The strategic management of supply reduction was poor. Until shortly before the inspection, there had been no supply reduction meetings and there was no extant supply reduction strategy. Most requested suspicion drug tests were not completed.

Recommendation: The prison should implement a supply reduction strategy, which is overseen by a multidisciplinary team at regular meetings. Action planning should ensure that all facets of the strategy, such as intelligence-led drugs testing, are carried out efficiently. (S52)

- 2.30** Since our inspection in April 2019, a coherent supply and demand reduction strategy had been developed that addressed many of the key risks the prison faced. The strategy's aims were delivered through an action plan that set objectives and timescales. However, there was no named individual accountable for delivery of these measures, which created a risk that actions would not be fully addressed.
- 2.31** A senior multidisciplinary group now met regularly to review the action plan. The plan included a range of security measures and better use of intelligence-led drug testing. However, intelligence-led drug testing did not take place at weekends, which resulted in a lack of action on some intelligence reports. Fluctuations in staffing cover had also affected performance in this area. Positive mandatory drug testing (MDT) rates had reduced from 29% to a 23% average but were still too high.
- 2.32** The approaches to reducing demand usefully included an emphasis on promoting well-being and facilitating access to specialist support services. The strategy needed to develop further to address more of the causative factors leading to prisoners' drug misuse, such as living conditions, relationships and limited access to purposeful activities.
- 2.33** We considered that the prison had made good progress against this recommendation.

Concern: There were ongoing weaknesses in physical security which had been identified at our last inspection. There was slow progress in securing cell windows, many of which were broken, and most wings still did not have CCTV coverage.

Recommendation: Physical security should be enhanced through the prompt replacement of windows and installation of CCTV coverage where necessary. (S53)

- 2.34** Work had continued on the window replacement project. Focusing primarily on G wing, a further 84 windows had been replaced since our inspection. Funding had been secured for further work, which was likely to focus on A wing, J wing and the reception building. However, some work was currently unfunded, with no timescales for completion. The prison intended to bid for further capital to secure funding in 2020-21.
- 2.35** At the time of our visit, CCTV was being installed on A wing, with funding also secured for work to be completed on J wing. C, D and G wings already had CCTV installed. Only E and F wings remained without any CCTV coverage or timescale for this work. As with the window replacement project, the prison intended to submit a further bid for this work in 2020-21.
- 2.36** We considered that the prison had made reasonable progress against this recommendation.

Staff-prisoner relationships

Concern: In our survey, only 57% of prisoners said they were treated with respect by staff. We received many reports of dismissive or unhelpful staff and observed poor prisoner behaviour going unchallenged. There was evidence that aspects of staff culture were obstructing positive engagement with and care for prisoners.

Recommendation: Managers should ensure that staff behave respectfully towards prisoners, actively supporting them and challenging poor behaviour, in line with the principles of a rehabilitative culture. (S54)

- 2.37** We observed some very positive and friendly staff-prisoner interactions during association, in activities and particularly between officers and wing workers. All the prisoners we met could name at least one officer who they trusted and respected. However, prisoners also told us that a proportion of officers were rude and unhelpful, and some felt this was true of half the staff. They described officers who did not take time to listen to them and who spoke to them disrespectfully. Some managers told us they were disappointed in the performance of some of their staff and said they struggled to secure improvement.
- 2.38** We continued to see prisoners breaking wing rules without being challenged by officers. For example, staff told us that it was hard to enforce the rule about prisoners not vaping on the landings, and prisoners told us that they were rarely challenged for doing so. Managers and staff needed to set and enforce clear standards of prisoner behaviour.
- 2.39** A regional manager from outside the prison investigated allegations of staff misconduct. This innovative approach emphasised the seriousness and importance of this area. Since May 2019, 72 investigations had been completed, of which 20 had resulted in formal disciplinary processes and five staff had resigned or been dismissed.
- 2.40** Key work* had restarted in January 2020 having almost completely stopped in August 2019, apparently because of staff shortages. Around two-thirds of prisoners had been allocated a key worker but some had not yet had an initial meeting. We saw some examples of excellent work focused on behaviour management and on progression, but this was not universal, and some prisoners told us that meetings took place at cell doors in the presence of their cell mate or in noisy conditions on the landings.
- 2.41** Arrangements for consultation with prisoners were still not effective. Wing consultation meetings were not frequent enough to demonstrate commitment to the process or to make progress on prisoners' concerns. The User Voice prisoner charity was still engaged and held weekly meetings with prisoner representatives, but the prisoner council had not met since October 2019 and prisoners told us that they were concerned the process was losing credibility.
- 2.42** We considered that the prison had made insufficient progress against this recommendation.

Daily life

Concern: Living conditions were cramped and did not provide an adequate living environment for most prisoners. The majority of prisoners shared a cell designed for one. Most toilets were very dirty and screening was usually poor. Pest infestation was an ongoing problem.

Recommendation: Cells should provide decent and hygienic conditions, including properly screened toilets and sufficient space for each occupant. (S55)

- 2.43** The prison now had a greater focus on environmental cleanliness and cell repairs. A programme of work had been developed. A clear and coherent plan was steering improvements, which ranged from providing accredited training to wing cleaners through to commissioning capital projects, such as replacing showers. We saw the results of the rolling programme of deep cleaning for cell toilets, although many still needed attention. The prison had established the ‘Clean rehabilitative, enabling and decent’ (CRED) initiative to progress the refurbishment of cells. Priority areas had been identified for action, and a small team of specially trained prisoners were working on six cells at a time. This work was valuable but progress was too slow, and increased capacity was needed to address the needs of the whole prison.
- 2.44** ‘Dignity checks’ by senior managers had been introduced to improve and maintain standards, with every cell audited quarterly. As a result, the environment for prisoners had improved since the inspection in April 2019. Despite this, cells had no curtains, picture boards or lockable cabinets, and we found flaking paintwork and graffiti. Privacy screening for toilet areas remained ineffective, with many prisoners improvising to maintain their dignity. The prison needed to carry out further sustained work to deliver and maintain adequate provision.
- 2.45** Few prisoners we spoke to complained of infestation, but we were made aware that mice and cockroaches remained a problem and there were efforts to address pest control. Specialist services had been commissioned when required, but keeping areas clean by maintaining the integrity of cells and outside areas was rightly regarded as the best approach to address this concern. Work was still needed to ensure decent standards.
- 2.46** Despite the prison’s energy and focus to deliver improvements and provide decent living conditions, most cells remained cramped and unsuitable for double occupancy, which remained the norm.
- 2.47** We considered that the prison had made insufficient progress against this recommendation.

Equality, diversity and faith

Concern: Equality and diversity work had been neglected in 2018. There had been no equality meetings, no monitoring of equality data and little consultation with prisoners in most protected groups. Discrimination incident reports often waited months for a response.

Recommendation: **The new equality strategy should cover all protected groups and be overseen by regular equality meetings to ensure effective implementation. It should include actions in relation to effective consultation, analysis of monitoring data and prompt response to diversity complaints. (S56)**

- 2.48** The equality strategy had not been updated since our inspection in April 2019, and there had been a lack of focus in this area. There had been only three equality meetings since our last inspection and their minutes did not demonstrate effective scrutiny or monitoring of data, particularly on the treatment of prisoners in protected groups. At the December 2019 meeting there was no analysis of any data, and minutes noted that the prison was awaiting the appointment of a new middle manager to lead on equality. However, at the time of our review this had still not happened, and no work had been carried out since then. The equality action plan had not been updated since March 2019.
- 2.49** There had been little focused work with protected groups. Some consultation and work with young adults had taken place after our last inspection but had ceased in June 2019. The prison had identified managers to lead on each protected characteristic but this had not been

coordinated. The User Voice forums in August, September and October 2019 recorded repeated requests for updates from the leads for the protected characteristics, but these never arrived and there had been no further meetings.

- 2.50** Discrimination incident reporting forms (DIRFs) were quality assured, but this had not led to sufficient improvements and the process was weak. Responses were often late and did not always fully address the issue raised, and many complaints were insufficiently investigated. For example, in response to one complainant, the prison said it was unable to access the adjudication records necessary to investigate the complaint because they were at another establishment, even though it would be perfectly possible for them to request records from other prisons.
- 2.51** We considered that the prison had made no meaningful progress against this recommendation.

Health, well-being and social care

Concern: The problems of ensuring that patients attended for primary care, specialist clinics, mental health care, substance misuse care and dental clinics remained unresolved since 2017. There was still no secure storage for patients with in-possession medicines and no prison-wide strategy for health and well-being, despite the good efforts of several departments to contribute to well-being and health. While there was some evidence of starting to address a few issues, the response had been inadequate.

Recommendation: The prison health care local delivery board should ensure that assertive action is taken to enable access to health care, safe storage of in-possession medicines, and a prison-wide strategy for health and well-being. (S57)

- 2.52** The prison had taken various steps since our April 2019 inspection to enable prisoners to attend health clinics more readily, and opportunities to access services had significantly improved. Dedicated officers facilitated movements to and from the health centre. This meant prisoners were not left for long periods in the waiting room before or after their appointments. In addition, many clinics were now run from the wings, which provided more flexible and enhanced access for prisoners, and particularly support for vulnerable prisoners.
- 2.53** There were no plans to introduce secure in-cell storage for prisoners' medication. This meant that prisoners were given in-possession medication weekly rather than monthly, and some had to receive supervised medicines due to cell-sharing arrangements. This potentially added time to the medicine rounds, with a subsequent impact on the prison regime.
- 2.54** Since our inspection, a prison-wide health and well-being strategy had been developed following stakeholder consultation, which included patients. The planned programme of activities and assigned responsibilities brought together different agencies, and envisaged close collaboration between the health department, prison and external partners. However, the strategy was not due to be launched until the spring of 2020. The health and well-being service continued to provide very good support for prisoners with mental health needs.
- 2.55** We considered that the prison had made reasonable progress against this recommendation.

Time out of cell

Concern: There were too few full-time activity places and attendance at allocated activities was poor. During our roll checks a third of prisoners were locked up during the working day. Access to outside exercise, PE and association was not good enough for many prisoners.

Recommendation: Managers should ensure that all prisoners have the opportunity to participate in a full and purposeful regime and are encouraged to attend activities. (S58)

- 2.56** In our roll check we found around 40% of the population locked in their cells during the working day, which was higher than the third we found at our inspection in April 2019. There were enough activity spaces for every prisoner to be engaged part-time, but only two-thirds were allocated to activities and 324 were unemployed. Attendance by those who were allocated to an activity was poor (see below).
- 2.57** Prisoners still had insufficient time out of cell to complete domestic chores and associate with each other. They also complained that time in the fresh air was too limited.
- 2.58** We considered that the prison had made no meaningful progress against this recommendation.

Education, skills and work

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.

Theme 1: What progress have leaders and managers made to improve the processes of induction and allocation to activities ensuring that all men can access an appropriate range of education, skills and work activities, including vulnerable prisoners?

- 2.59** At the time of the inspection, managers had not planned the education induction sufficiently well to provide prisoners with enough information on the available options. The education provision broadly met prisoners' needs, although there was an extremely limited range of education and meaningful work for vulnerable prisoners.
- 2.60** At the monitoring visit we found that the content and delivery of the education induction had improved and, combined with a useful handbook, provided sufficient information for prisoners about the education and training options available. However, prisoners did not receive sufficient support and guidance to identify the most suitable education and work activities to meet their individual needs.
- 2.61** Staff had reduced the number of prisoners who had not attended induction from 178 at the inspection to around 45 at this visit. However, arrangements to ensure all new entrants attended were ineffective. Prison staff did not let the tutor know how many prisoners would attend from the first night wing, and often brought them late to the session.
- 2.62** The educational offer for vulnerable prisoners had reduced further and consisted of only one short functional skills lesson each day. The range of education courses for mainstream prisoners remained broadly in line with their needs.
- 2.63** The process of allocation to activities did not make effective use of the places available, resulting in about a third of the population being unemployed. Allocations to education courses did not involve education staff sufficiently or take enough account of prisoners'

ability to complete the course. Compared with the inspection, a significantly higher number of prisoners allocated to education now did not start their courses. Around a third of prisoners who did start a course did not complete it, which was much higher than at the April 2019 inspection. Managers did not have a clear and comprehensive strategy to remedy this.

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

Theme 2: What progress have leaders and managers made in quality assuring and improving the quality of teaching, learning and assessment received by all prisoners, including those with learning difficulties, ensuring all prisoners attend education, skills and work activities well?

2.65 At the inspection in April 2019, the quality of teaching, learning and assessment, particularly in English and mathematics lessons, required improvement. Many prisoners who required additional support did not receive it and, consequently, they did not progress to the same extent as their peers. Quality assurance systems had failed to identify and rectify these deficiencies. Attendance at lessons, especially functional skills, was too low.

2.66 During this visit we found that quality assurance procedures for education and training were effective. Underperforming staff had either ceased to be employed or had received coaching to improve. Consequently, the quality of teaching was better, especially in functional skills, although the use of individual learning plans and the development of prisoners' English skills outside dedicated English lessons still required improvement.

2.67 Prison managers had developed procedures for measuring the quality of learning and skills within industries and work areas, and these had begun to have a positive impact on teaching. Prison staff had undertaken appropriate training and developed observation forms to underpin these processes. Observations of learning had taken place in industries, the gym and some work areas, and further observations were planned.

2.68 The quality and extent of support for prisoners with learning difficulties and/or disabilities was much improved. Prisoners' support needs were systematically assessed during their induction. Education and prison staff, including those in industries and other work areas, used the outcomes of the assessment well to understand prisoners' needs and plan how to meet them. Links between education staff, key workers, health care and Shannon Trust literacy mentors were becoming more effective and contributed to improving the support for prisoners with learning difficulties and/or disabilities.

2.69 Despite managers' efforts to encourage prisoners to attend activities, including the appointment of a small number of prisoner activity representatives, attendance remained stubbornly low.

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

Theme 3: What progress have leaders and managers made in raising the achievement of prisoners undertaking English and mathematics qualifications at level 1, ensuring they use data well to monitor and secure good education, training and employment destinations for prisoners on release?

2.71 At the inspection, teaching in English and mathematics was weak and the proportion of prisoners who achieved functional skills qualifications in these subjects at level 1 was too low. At that time, neither the prison nor the community rehabilitation company (CRC) had any information on whether prisoners entered education, training or employment on release, and so did not know whether the activities they had been offered had helped them.

- 2.72** At the monitoring visit we found that teaching in English and mathematics had improved, although too few prisoners completed a suitable qualification in these subjects. The majority of prisoners who began courses in English and mathematics did not complete them and did not gain their qualification. For example, of the 105 prisoners who had started a level 1 English course since the inspection, just 14 had completed or were continuing. Of the 113 prisoners who started a level 1 mathematics course, just 43 had completed or remained on the course. The few who did stay until the end were mostly successful in gaining the qualification, which was an improvement.
- 2.73** Although the CRC now provided statistical data on the proportion of released prisoners who entered employment, this was not detailed enough to identify the kind of employment, education or training. As a result, managers still did not know if the activities offered in the prison helped them in this and did not have a clear strategy to rectify this.
- 2.74** We considered that the prison had made insufficient progress against this recommendation.

Reducing risk, rehabilitation and progression

Concern: The strategic management of reducing reoffending and public protection was weak. There was poor attendance at strategic meetings and no action plan to drive and monitor progress. This resulted in poor communication and the inability to share important risk information and concerns thoroughly.

Recommendation: All relevant departments and agencies should play a full part in strategic and risk management work, including relevant meetings. (S60)

- 2.75** The strategic management of reducing reoffending work had improved. There were now monthly meetings and extensive data collection, which allowed managers to raise concerns. However, senior managers - particularly from residence and regimes – still needed to be involved. Without cooperation across the whole prison, it seemed unlikely that persistent and complex issues, such as low attendance at activities, could be resolved.
- 2.76** Managers had not yet improved attendance at the inter-departmental risk management team meeting. This meeting should help manage the risks posed by the most dangerous prisoners, both while they are in prison and on release, and therefore needs to both disseminate and receive information about risks and behaviours. The failure of various departments to attend this meeting meant that it was not fully effective. The most notable absences were representatives from residence and security.
- 2.77** We considered that the prison had made insufficient progress against this recommendation.

Concern: Over half the eligible population did not have an up-to-date assessment of their risk and needs and the prison had no plan to address the problem. This had resulted in most prisoners being transferred out of Pentonville without a sentence plan to inform the move and aid progression.

Recommendation: All prisoners should have an up-to-date OASys assessment. (S61)

- 2.78** The prison understood that there were now only 38 outstanding OASys (offender assessment system) assessments. We were told that the reduction had been achieved by consistently allocating staff to OASys work and by using overtime. However, we were not shown any data on how the reduction had been achieved over time, and it was not clear how it would be sustained.

- 2.79** In recent weeks, around 60% of prisoners transferred out did not have an OASys assessment. Almost 30% of the outstanding cases were more than six months overdue, and some of these prisoners were now very close to release.
- 2.80** We considered that the prison had made reasonable progress against this recommendation.

Interventions

Concern: Too many prisoners were left without an initial resettlement plan and even more did not have their plan reviewed before release. This affected prisoners' ability to access interventions and support. Those who did have a resettlement plan generally had a good level of support, but the CRC had poor oversight of its release responsibilities and knowledge of practical release arrangements.

Recommendation: The CRC should ensure that all eligible prisoners receive an initial resettlement plan which is reviewed before their release. (S62)

- 2.81** The CRC still struggled to achieve its targets for completing initial assessments and reviews. On average, 86% of initial assessments had been completed over the previous nine months, which was better than the 78% at our April 2019 inspection. Reviews were still harder to achieve and 68% of reviews had been completed, the same as at our inspection.
- 2.82** The CRC was hampered by staffing shortages, routine regime restrictions (such as landings on patrol state), planned shutdowns (such as training days), unplanned shutdowns (for example, following incidents) and by difficulties in locating prisoners.
- 2.83** We considered that the prison had made insufficient progress against this recommendation.

Section 3. Appendix

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