Report on a scrutiny visit to

HMP Preston

by HM Chief Inspector of Prisons

4 and 11–12 August 2020

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

Printed and published by:
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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 some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Assessment, care in custody and teamwork (ACCT)
Case management for prisoners at risk of suicide or self-harm.

Care-experienced
Describes a person who has experience of being in local authority care, regardless of their placement length, type or age.

Certified normal accommodation (CNA) and operational capacity
Baseline CNA is the sum total of all certified accommodation in an establishment except cells in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged cells, cells affected by building works, and cells taken out of use due to staff shortages. Operational capacity is the total number of prisoners that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

Challenge, support and intervention plan (CSIP)
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.

Community rehabilitation company (CRC)
Since May 2015, rehabilitation services, both in custody and after release, have been organised through CRCs, which are responsible for work with medium- and low-risk offenders. The National Probation Service (NPS) has maintained responsibility for high- and very high-risk offenders. Following a change in policy, all offender management will be brought under the NPS by spring 2021.

Early release on compassionate grounds
Determinate-sentenced prisoners may be considered for early compassionate release for medical reasons or in tragic family circumstances. Life or indeterminate sentence prisoners are only eligible to be considered for compassionate release in medical circumstances.

emailaprisoner
A scheme that allows families and friends of prisoners to send emails into the prison.

End of custody temporary release scheme
A national scheme through which risk-assessed prisoners, who are within two months of their release date, can be temporarily released from custody. See:
https://www.gov.uk/government/publications/covid-19-prison-releases

Exceptional delivery model
A suite of EDMs have been published to guide prisons through the construction of local Regime Recovery Management Plans (RRMPs). An EDM is a guide containing the principles that must be incorporated into a local plan for each element of regime delivery.

HMPPS
Her Majesty's Prison and Probation Service.

Key worker scheme
The key worker scheme operates across the closed male estate, with prison officers managing around five to six prisoners each on a one-to-one basis.

Listeners
Prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners.

PAVA
Incapacitant spray.

Prison offender managers (POMs)
Introduced along with core offender management as part of the Offender Management in Custody (OMiC) model.

Protective isolation (isolating)
Prisoners who are symptomatic or positive for COVID-19 are held in isolation to protect other prisoners.

Reverse cohort unit (RCU)
Unit where newly arrived prisoners are held in quarantine for 14 days.

Shielding
Prisoners who have health conditions that make them vulnerable to infection are held for at least 12 weeks in a shielding unit.

Short scrutiny visit (SSV)
A type of HM Inspectorate of Prisons (HMI Prisons) visit in which up to three similar establishments (for example, young offender institutions or local prisons) are visited. The aim of these visits is not to report on how an establishment meets HMI Prisons' *Expectations,* as in a regular full inspection, but to give a snapshot of how it is responding to the COVID-19 pandemic and to share any notable positive practice found.

Social care package
A level of personal care to address needs identified following a social needs assessment undertaken by the local authority (i.e. assistance with washing, bathing, toileting, activities of daily living etc, but not medical care).

Social/physical distancing
The practice of staying two metres apart from other individuals, recommended by Public Health England as a measure to reduce the transmission of COVID-19.

Introduction

This report discusses the findings from a scrutiny visit (SV) to HMP Preston. The SV methodology develops the 'short scrutiny visit' (SSV, see Glossary of terms) approach that HMI Prisons has used to provide independent oversight of custodial establishments since April 2020. Our previous approach monitored outcomes for prisoners in a small number of key areas at a time when regimes were severely restricted. While SVs are still far more limited in scope than our full inspections, they are increasing the intensity of scrutiny as prisons enter a phase of recovery. SVs examine the treatment and conditions of prisoners in greater detail, and focus in particular on the pace of recovery and proportionality of treatment, while ensuring the safest possible inspection practices.

HMP Preston is a local prison which, at the time of our visit, held around 650 adult males drawn from Lancashire and other parts of the North West. While the population was lower than at our previous inspection in 2017, the prison was still severely overcrowded. As we have found elsewhere, the early release schemes brought in to relieve pressure on places during the pandemic had been ineffective, with no prisoners released following assessment. HM Prison and Probation Service (HMPPS) had classed the prison as a COVID-19 outbreak site until 10 July. At the time of our visit, there were no confirmed prisoner cases. A small number of staff were shielding or away from work while awaiting test results.

The prison dates from the 18th century, and some of the accommodation was deteriorating or, as in the case of the very cramped reception area, barely fit for purpose. In such areas, social distancing was all but impossible, and it was difficult in much of the rest of the prison because of its cramped design and overcrowding. We saw few attempts by staff and prisoners to socially distance even where it was achievable.

The reverse cohort unit (RCU, see Glossary of terms) was large and busy. It was evident that it could not be run practically in line with best practices – such as the consistent separation of prisoners arriving on different days – while also delivering basic facilities, such as daily showers and telephone calls. This undermined the effectiveness of the unit, as did the staff from other wings walking unnecessarily through the RCU.

While most prisoners understood the reasons for the restrictions imposed in March 2020, many told us they were confused and concerned about the possible next steps. There had been a lack of investment in communications technology, and the prison had no in-cell telephones or prisoner information kiosks, and no prison television channel. This particularly disadvantaged prisoners with literacy or language difficulties.

Nearly all prisoners received the restricted regime reliably, including daily access to telephones and showers, and exercise in the open air six days a week. However, most were still locked up for 22.5 hours a day, usually in shared cells that were not designed to hold more than one prisoner. Isolated prisoners (those symptomatic or positive for COVID-19, see Glossary of terms) were allowed out of their cells for only 15 minutes a week to shower. This was unacceptable and, given that there was only one such prisoner during our visit, wholly avoidable.

Following an initial reduction, the incidence of violence was now starting to increase. Use of force had increased in May and June 2020 to levels above those before the regime had been restricted, but it had started to reduce again. There was evidence that some use of force had resulted from prisoners being frustrated at the prolonged restrictions and a lack of purposeful activity. While managers tackled inappropriate use of force robustly where it was identified, we were concerned to find that staff often did not switch on body-worn cameras when they should have used them. This required a stronger management response.

Self-harm was at a similar level to that before the restricted regime was imposed. Assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm was generally reasonable, and Listeners (see Glossary of terms) were available at most times.

There was a very high level of mental health need in the prison. In our survey, two-thirds of prisoners said they had mental health problems and 11 were waiting to be transferred to a secure hospital. Some prisoners we interviewed described a decline in their mental well-being during the restricted regime.

Primary and mental health services were stretched, and there were long waits for routine and some urgent assessments. Health care staff were working hard to improve matters and there were early signs of recovery, as staff who had been shielding returned to work. The psychosocial support team had a limited presence in the main prison but had recently resumed one-to-one work in the substance misuse recovery unit. In a positive move, wing staff had also supported peer workers to resume some useful group support in the recovery unit.

We observed generally good staff-prisoner relationships, although there were routine welfare checks only for the most vulnerable groups. Prisoner consultation had recently resumed. The prison was clean and additional cleaning was being carried out daily. Prisoners also reported good access to cleaning materials for their cells.

Strategic oversight of equality work had also recently resumed; this was needed given some negative reporting by black and ethnic minority prisoners in our survey. Support for prisoners who did not speak English was generally limited, and there was little translated material about the regime. Despite significant staff shortages, the chaplaincy had maintained a presence in the establishment.

Education providers had not yet returned to the prison and few prisoners were in work. Library books and activity packs were distributed to wings, but many prisoners we spoke with did not know about the latter.

There was some good family support work. Social visits had been reintroduced, but they had been suspended shortly after as a result of local area restrictions. Video calling to family and friends was appreciated by most of the prisoners who had used it, but had only been available for just over a week. Prisoners had regular access to telephones but often at times that their families were at work or otherwise unavailable, and calls were limited to 15 minutes. The prison had not used the HMPPS-supplied mobile phones creatively to overcome this problem.

Sentence planning and risk assessment processes were up to date, which was positive, and most risk management procedures were working reasonably effectively. However, the continuing lack of face-to-face interviews limited the effectiveness of some provision. No prisoners had been released since March 2020 without some form of accommodation, which was positive.

Managers and staff at Preston had shown considerable resilience in managing the changing demands of the COVID-19 period. Prisoners had shown similar fortitude, although the costs to their mental health of such an extended period of restriction were increasingly evident. There were some obvious changes that the prison should have made to improve matters, such as ensuring that prisoners in protective isolation had more time out of cell. More ambition in general would also have improved the pace of recovery, and alleviated the evident and growing strain on prisoners. This is partly a matter for local managers, but there was no doubt that they needed to feel they had the autonomy from HMPPS to innovate.

At our previous full inspection, we commented that Preston had many strengths but that with more imagination it could and should deliver more. That judgement also held true during this scrutiny visit.

Peter Clarke CVO OBE QPM
HM Chief Inspector of Prisons
August 2020

Fact page

Task of the establishment
HMP Preston is a Category B local resettlement prison for young adult and adult males.

Certified normal accommodation and operational capacity (see Glossary of terms)

Prisoners held at the time of this visit:	650
Baseline certified normal capacity:	426
In-use certified normal capacity:	426
Operational capacity:	715

Prison status (public or private) and key providers
Public

Physical health provider:	Spectrum
Mental health provider:	Tees, Esk and Wear Valleys NHS Foundation Trust
Substance misuse treatment provider:	Spectrum
Prison education framework provider:	Novus
Community rehabilitation company (CRC):	Cumbria and Lancashire Community Rehabilitation Company
Escort contractor:	GEOAmey

Prison group
North West

Brief history
HMP Preston was built in 1790 and later enlarged as a radial prison. The four wings leading from the centre building were constructed between 1840 and 1895. Since 1790, it was used as a civil defence centre and a naval detention quarters, before becoming a training prison for category C prisoners. In 1990 it became a local prison.

Short description of residential units

A1	–	Separation and care unit
A2	–	Complex prisoner unit
A3/4/5	–	General population
B	–	Vulnerable prisoner unit
C1	–	Reverse cohort unit, RCU (see Glossary of terms)/Induction and first night centre
C2	–	" "
C3	–	26 RCU spaces annex (gated off)/general population
C4	–	32 RCU spaces annex (gated off)/general population
D	–	General population
F	–	Risk-assessed workers' unit accommodating prison orderlies.
G	–	Substance misuse recovery unit
H	–	Health care

Name of governor and date in post
Steven Lawrence, April 2016

Independent Monitoring Board chair
David Kelshaw

Date of last inspection
6-7 March 2017

About this visit and 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 During a standard, full inspection HMI Prisons reports against *Expectations*, the independent criteria against which we inspect outcomes for those detained. Inspection teams of up to 12 people are usually in establishments across two weeks, speaking to prisoners and staff, observing prison life and examining a large amount of documentation and evidence. The COVID-19 pandemic means that it is not currently possible to carry out inspections in the same way, both for health and safety reasons and because it would not be reasonable to expect places of detention to facilitate a full inspection, or to be assessed against our full set of *Expectations*, at this time.

A4 HMI Prisons has therefore developed a COVID-19 methodology to enable it to carry out its ongoing, statutory duty to report on treatment and conditions in detention during the current challenging circumstances presented by COVID-19. The methodology has been developed together with health and safety guidance and in line with the principle of 'do no harm'. The methodology consists of three strands: analysis of laws, policies and practice introduced in places of detention in response to COVID-19 and their impact on treatment and conditions; seeking, collating and analysing information about treatment and conditions in places of detention to assess risks and identify potential problems in individual establishments or developing across establishment types; and undertaking scrutiny visits to establishments based on risk.

A5 HMI Prisons first developed a 'short scrutiny visit' (SSV) model in April 2020 which involved two to three inspectors spending a single day in establishments. It was designed to minimise the burdens of inspection at a time of unprecedented operational challenge, and focused on a small number of issues which were essential to the safety, care and basic rights of those detained in the current circumstances. For more on our short scrutiny visits, see our website: http://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/short-scrutiny-visits/.

A6 As restrictions in the community are eased, and establishments become more stable, we have expanded the breadth and depth of scrutiny through longer 'scrutiny visits' (SVs) which focus on individual establishments, as detailed here. The SV approach used in this report is designed for a prison system that is on the journey to recovery from the challenges of the COVID-19 pandemic, but recognises that it is not yet the right time to reintroduce full inspections. SVs provide transparency about the recovery from COVID-19 in places of detention and ensure that lessons can be learned quickly.

A7 SVs critically assess the pace at which individual prisons re-establish constructive rehabilitative regimes. They examine the necessity and proportionality of measures taken in

response to COVID-19, and the impact they are having on the treatment of and conditions for prisoners during the recovery phase. SVs look at key areas based on a selection of our existing *Expectations*, which were chosen following a further human rights scoping exercise and consultation.

A8 Each SV report includes an introduction, which will provide an overall narrative judgement about the progress towards recovery. The report includes a small number of key concerns and recommendations, and notable positive practice is reported when found. Reports include an assessment of progress made against recommendations at a previous SV, but there is no assessment of progress against recommendations made at a previous full inspection. Our main findings will be set out under each of our four healthy prison assessments.

A9 SVs are carried out over two weeks, but will entail only three days on site. For more information about the methodology for our scrutiny visits, including which *Expectations* will be considered, see our website: http://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/scrutiny-visits/

Summary of key findings

Key concerns and recommendations

S1 Key concerns and recommendations identify the issues of most importance to improving outcomes for prisoners and are designed to help establishments prioritise and address the most significant weaknesses in the treatment and conditions of prisoners.

S2 During this visit we identified some areas of key concern, and have made a small number of key recommendations for the prison to address.

S3 **Key concern:** There was a lack of investment in the variety of communication methods that we have seen in other prisons; for example, there were no information kiosks, no dedicated prison TV channel and no in-cell telephones, which particularly disadvantaged prisoners with literacy or language difficulties. The HMPPS-supplied mobile phones were not widely used.

Key recommendation: There should be investment into communications technology and better use of existing resources to improve information flow to and communication with prisoners. (To HMPPS and the governor)

S4 **Key concern:** The reverse cohort unit (RCU) was very large and could not be run practically in line with best practices, such as the separation of prisoners arriving on different days, while also delivering basic facilities, such as daily showers and telephone calls. The unit's effectiveness was further reduced by prisoners mixing during exercise, and staff from other wings walking through it unnecessarily.

Key recommendation: Reverse cohorting should be implemented consistently to minimise the risk of spreading infection. The unit should be resourced and organised sufficiently to achieve this objective. (To governor)

S5 **Key concern:** Violence was increasing, and use of force had been higher than previously in the two months following the introduction of the restrictions. The relevant documents we reviewed did not always demonstrate the use of de-escalation techniques, and even though body-worn cameras were available, these were not always turned on during incidents.

Key recommendation: Staff should turn on body-worn cameras at the earliest opportunity to ensure that use of force incidents are recorded. Managers should effectively address staff reluctance to use body-worn cameras. (To governor)

S6 **Key concern:** There was still little activity for prisoners and the pace of progress was slow, with an increasing impact on the well-being of prisoners. Most prisoners spent no more than 1.5 hours out of their cells on a typical day. The prison could have done more to alleviate this problem. Some prisoners were undertaking multiple work roles while others had none. The one prisoner held in protective isolation (see Glossary of terms) had only 15 minutes out of cell a week, which was unacceptable and unnecessary. The HMPPS standardised recovery plans were too limiting on local discretion.

Recommendation: There should be a local, tailored prison recovery plan that outlines how and when the restrictions can be lifted, and how to provide purposeful activity to the greatest possible number of prisoners. Prisoners in protective isolation should be enabled to spend some time out of their cell every day. (To HMPPS and governor)

S7 **Key concern:** Pressures on health care staffing and their limited access to prisoners had created long waiting times for health care appointments, with some prisoners waiting up to 13 days for an urgent appointment with a GP. There was a very high level of mental health need. In our survey, two-thirds of prisoners said they had mental health problems, and those we interviewed described a decline in their mental well-being during the restricted regime. Eleven prisoners had needs so serious that they were waiting to be transferred to a secure hospital. Only 13% of prisoners surveyed said it was easy to get a mental health appointment. Routine mental health assessments had ceased, with waiting times now at 16 weeks.

Key recommendation. The prison should work with its health partners to ensure that immediate action is taken to mitigate the deterioration in prisoners' mental and physical health during the COVID-19 crisis. This should include sufficient staffing to give prisoners prompt access to urgent and routine health care. (To governor)

S8 **Key concern:** The vast majority of prisoners had not been seen by prison offender managers or resettlement workers employed by the community rehabilitation company. Prisoners were anxious about their progression or release, and frustrated at the lack of information and support available.

Recommendation: HMPPS and the governor should work with key partners providing offender management and resettlement services to enable their staff to resume routine and private contact with prisoners safely. (To HMPPS and governor)

Notable positive practice

S9 We define notable positive practice as innovative practice or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

S10 Inspectors found the following examples of notable positive practice during this visit.

- A member of the safer custody team made daily contact with prisoners on case management for risk of suicide or self-harm (see paragraph 1.23).
- Listeners had been given a dedicated telephone number to contact the Samaritans for support, as the Samaritans were currently unable to visit the establishment in person (see paragraph 1.24).
- The prison had provided tablet computers on around 14 occasions to allow prisoners to contact their families in exceptional circumstances, such as the livestream of funerals, or to see their newborn children or end-of-life relatives (see paragraph 4.5).
- The family liaison team had introduced a new service to allow prisoners to send and/or receive an electronic photograph each month (subject to public protection restrictions) (see paragraph 4.4).

Section 1. Safety

In this section, we report mainly on leadership and management; arrival and early days; managing prisoner behaviour; and support for the most vulnerable prisoners, including those at risk of self-harm.

Leadership and management

1.1 The prison was carrying out the national directives issued by HM Prison and Probation Service (HMPPS) on how to contain and prevent the spread of COVID-19. The prison used little discretion beyond these requirements.

1.2 In our survey, most staff felt they were being kept well informed about what was expected of them. While staffing levels were adequate, our staff survey indicated significant fatigue. Managers had some concerns about how to maintain sufficient staffing as the prison increased its pace of recovery. New recruits had not yet been trained following the suspension of prison officer training.

1.3 Information notices placed under cell doors or left in open areas on the wings were the main means of delivering information to prisoners. In our survey, the vast majority of prisoners (88%) said they understood the restrictions, and most also felt that the reasons for them had been explained. However, some prisoners told us that they were confused about the reasons for the continued restrictions and had not received enough information to explain what was happening. In our staff survey, about half of staff also said they were unaware of the prison's recovery plan. There was a lack of investment in the variety of communication methods that we have seen in other prisons; for example, there were no information kiosks for prisoners, no dedicated prison TV channel, and no in-cell telephones, which particularly disadvantaged prisoners with literacy or language difficulties. Mobile phones were available but not widely used (see paragraph 4.3). (See key concern and recommendation S3.)

1.4 In our staff survey, the majority of respondents said it was difficult to maintain distance from both staff and prisoners. Social distancing was generally poor throughout the prison, and made more difficult by the cramped environment. We saw little attempt to distance even where it was possible. In our survey, about a third of prisoners did not feel that they had been kept safe from the virus. In our staff survey, only 5% felt that reasonable steps had not been taken to keep prisoners safe.

1.5 There was insufficient focus on easing the high level of isolation experienced by some prisoners. None of those we spoke to who were shielding, in protective isolation or on the reverse cohort unit (see Glossary of terms) were aware of having a key worker. Whereas nearly all prisoners had regular access to exercise, telephone calls and showers, those in protective isolation had an unacceptably poor experience. During our visit, one prisoner was in isolation as his cellmate had tested positive for COVID-19 and subsequently been released. The prisoner himself had tested negative but was still required to isolate. He described how hard this had been for him. His door was normally open only for a minute when meals were brought to him. He felt the air in his cell was heavy and stale, and he had been hot and short of breath in the previous few days when outside temperatures were high: 'If they could just let me have 10 minutes every day for a shower and to let some air into the room, that would make a big difference.' He said he tried to sleep for most of the day to make time pass more easily. As he was the only prisoner in isolation there was no doubt that the prison could have safely given him more time out of his cell (see also paragraph 3.1 and key concern and recommendation S6.).

Arrival and early days

1.6 Preston was a designated reception prison and received around 10 new arrivals a day. The reception was in poor physical condition and cramped. The lack of space meant that social distancing was not usually possible. Prisoners due for court appearances were moved from several different wings and then all held together in the same holding room. Two prisoners were then handcuffed together to be transferred to the cellular vehicle.

1.7 Reception processes were generally swift and prisoners we spoke to were mostly positive about their experience. Peer workers provided support to new arrivals. However, officers conducted interviews at an open desk rather than in a private room, which compromised confidentiality and may have inhibited prisoners from disclosing important information.

1.8 New arrivals were offered a shower and telephone call and received a basic reception pack. Depending upon the day of arrival, they could wait up to two weeks to receive their first prison shop order, which increased the chances of debt and bullying (see also paragraph 2.8).

1.9 New arrivals were located on to C wing for 14 days in the designated reverse cohort unit (RCU, see Glossary of terms). They were given an induction booklet which contained some useful information and was available in several languages. We were told that staff would go through this with prisoners on the day of arrival. However, some prisoners told us that they received just the booklet and no further information from staff. Staff told us that professional interpreting services were used with non-English speakers.

1.10 The regime on the RCU was similar to the rest of the prison, but all meals and medicines were delivered to the cell door. Prisoners were allowed out of their cells for one hour a day to exercise and half an hour for telephone calls and showers.

1.11 Preston was one of the most overcrowded prisons in the country, and population pressures meant that it was struggling to implement best practices in cohorting procedures. This was compounded by the prison's physical design and layout. The RCU was designated to hold 178 prisoners, which meant that most new arrivals had to share cells, including prisoners arriving on different days. Ideally, new arrivals in the unit should have only been mixing with those who arrived on the same day. We observed staff who did not work on the unit walking through the RCU. Prisoners who had arrived on different days were also able to mix on the exercise yard. (See key concern and recommendation S4.)

Managing behaviour

1.12 In our survey, around a quarter of prisoners said they felt unsafe; 22% reported victimisation or bullying behaviour from other prisoners, and about a third reported victimisation by staff. Following an initial reduction in April 2020, the incidence of violence was increasing. There had been 32 recorded prisoner-on-prisoner assaults and 10 assaults on staff in the three months following the implementation of the restricted regime, including six serious assaults on prisoners and three on staff.

1.13 The prison's response to violence was limited to adjudications and police referrals. There had been no recent use of challenge, support and intervention plans (CSIPs, see Glossary of terms). At the start of the restrictions, the independent adjudicator had not conducted hearings and the most serious offences were dealt with by the establishment. However, virtual video-call hearings were now taking place, having been introduced around six weeks before our visit.

1.14 Support for victims of violence or other antisocial behaviour was limited. Safety intervention meetings (SIMs) had been suspended at the start of the restrictions; we were told this was a result of limited space to hold meetings. Alternatives such as telephone meetings were not used.

1.15 The safer custody department produced a weekly report and circulated it to each department with key concerns, although these were not routinely actioned. For example, on one report we reviewed, a prisoner was repeatedly referred for CSIP without further action.

1.16 In May and June 2020, the use of force had increased to levels higher than those before the restricted regime, but it had started to reduce again in July. Some incidents could be attributed to an increase in frustration from prisoners during the prolonged regime restrictions. For example, the documents showed that some prisoners had refused to go back to their cells at the end of their short allotted time out of cell, which had resulted in staff using force to guide them back.

1.17 Formal scrutiny of the use of force had recommenced in June after being suspended at the start of the pandemic. There was evidence that managers were tackling inappropriate use of force, with three investigations commissioned and two members of staff suspended. Incidents involving batons or PAVA incapacitant spray (see Glossary of terms) were subject to review by the deputy governor. Some of the documents we reviewed lacked sufficient evidence of de-escalation. Despite the availability of body-worn cameras for staff to record incidents, these were often not turned on when required. Staff reluctance to use the cameras was a known and longstanding problem, which had yet to be resolved. (See key concern and recommendation S5.)

1.18 We found examples where precautions to minimise the risk of COVID-19 spreading had not been considered. For example, in two cases a planned relocation of prisoners to the segregation unit had taken place without consideration of the use of gloves and masks by staff.

1.19 The segregation unit was clean and attempts had been made to soften the environment. The prisoner maintenance team, Q branch (see paragraph 2.4), had recently refurbished the cells. Unit staff were friendly and approachable, and prisoners were generally positive about their treatment on the unit. Segregated prisoners had access to a daily shower, telephone call and exercise. The segregation documents we reviewed did not evidence regular daily mandatory visits by health care staff. The Independent Monitoring Board (IMB) was not currently participating in segregation review meetings.

Support for the most vulnerable, including those at risk of self-harm

1.20 HMPPS had designated the prison as a virus outbreak site until 10 July 2020; 11 prisoners and a number of staff had been confirmed as having COVID-19. At the time of our visit, one prisoner was shielding on a normal wing. It was positive that the regime for shielding prisoners was the same as the rest of the population (see paragraph 3.1). However, the one prisoner who was in protective isolation during our visit was allowed out of his cell only once a week for 15 minutes to take a shower, which was unacceptably poor (see also paragraph 3.1 and key concern and recommendation S6).

1.21 There was a very high level of mental health need in the population (see paragraph 2.20 and key concern and recommendation S7.) The number of recorded self-harm incidents was similar to the levels before the restrictions had been imposed at the end of March 2020. In the six months before then there had been 348 acts of self-harm by 91 prisoners; 13

prisoners accounted for 119 incidents. Since the implementation of the restricted regime, there had been five serious acts of self-harm for which prisoners required medical treatment. The prison had conducted learning reviews following each incident and was acting upon the recommendations. There was some evidence (from staff, prisoners and documentation) that prisoners were becoming frustrated with the lack of meaningful interaction and purposeful activity, and long days confined to cells.

1.22 In our survey, 21% of respondents said they had been on assessment, care in custody and teamwork (ACCT) case management for risk of suicide or self-harm, and 44% of them reported feeling cared for by staff. The ACCT documentation we reviewed indicated that case reviews were mostly multidisciplinary and had mental health team input, and care maps were generally good. However, entries in ACCT documentation often lacked evidence of meaningful staff interaction with prisoners, and some initial assessments were poor. In one case, there had been no assessment of a prisoner in protective isolation, even though alternatives to face-to-face contact, such as mobile phones and laptops, were available.

1.23 It was positive that a member of the safer custody team made daily contact with prisoners on ACCT, and key workers provided additional support to them. There was little evidence of regular engagement by prison staff with prisoners' families. Most prisoners told us that their cell bell would be responded to within a reasonable time.

1.24 There were 13 trained Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) and the system was still functioning well. They provided additional support in the RCU and reception. However, if a prisoner required support after 11pm, a Samaritans phone was the only available option, and these had not always worked effectively. Although Listeners no longer had face-to-face support meetings with the Samaritans, they had been given a designated number on their telephone accounts to make contact for support, which was positive. In addition, the safer custody team met Listeners regularly to support them during this period.

Section 2. Respect

In this section, we report mainly on staff-prisoner relationships; living conditions; complaints, legal services, prisoner consultation, food and canteen; equality, diversity and faith; and health care.

Staff-prisoner relationships

2.1 In our survey, 70% of prisoners said that staff treated them with respect. Most prisoners we interviewed said staff were helpful, and we observed staff dealing with them in a friendly manner. However, interactions between staff and prisoners were generally limited by the regime to functional conversations that took place when prisoners were being unlocked or returning from exercise.

2.2 Only 31% of prisoners in our survey said a member of staff had spoken with them in the past week about how they were getting on. Regime constraints and the suspension of key worker sessions for most prisoners meant there were fewer in-depth conversations or one-to-one sessions.

2.3 Prisoners considered to be most vulnerable, such as care-experienced prisoners (see Glossary of terms), those on the health care unit and younger prisoners, had regular key worker welfare checks. Prisoner information desk (PID) workers remained available on the wings, but prisoners had very limited time to access this support.

Living conditions

2.4 The living areas of the prison, including the communal areas of the wings, were clean. Recent refurbishment and improvements to some of the communal shower areas had enhanced privacy, and the prison was seeking funding to continue this work. A maintenance team of prisoners, 'Q branch', had been set up before the pandemic and had been able to continue working. We saw prisoners employed in the Q branch painting the landing areas of the wings. Cleaning orderlies also continued to work on the wings and were undertaking additional cleaning, such as wiping down handrails and door handles. We were told that the communal telephones were wiped down after each use.

2.5 Many prisoners shared cells that were cramped and too small for two. Prisoners told us they found it especially difficult to spend so much of their day in a small and stuffy shared cell in the hot weather during our visit. Clothing changes took place, but many prisoners found them not frequent enough, especially those who were exercising in their cells. There was a daily opportunity for cell cleaning, and most prisoners said they could access cleaning materials. However, many felt that was too little time to clean their cells during the half-hour period for them to do this as well as use the telephone and shower.

Complaints, legal services, prisoner consultation and food and shop

2.6 There had been an increase in the number of complaints made in the previous three months, doubling between April and May 2020 and continuing to rise in June. Some responses were taking longer, and there had been no quality assurance of responses from February until shortly before our visit. Applications were logged, and responses were monitored.

2.7 In our survey, 47% of prisoners said the food was at least reasonable. However, many complained about the quality of meals and lack of variation. There had been some positive results from the recently restarted prisoner consultation. As a result, meal choices that had been removed at the start of the pandemic had resumed with the usual four-weekly menu choices. Packs of extra snacks were also provided with lunch.

2.8 Prison shop orders continued to run as usual. but some prisoners complained that catalogue orders took longer to arrive, and new arrivals could wait up to two weeks to receive their first shop order (see also paragraph 1.9).

Equality, diversity and faith

2.9 The strategic oversight of equality work had been suspended at the start of the restricted regime but had recently resumed. It was positive that a forum for each of the protected groups had taken place. However, there was uncertainty over timings of future forums due to a lack of staff time. Some prisoners complained that they had been told they could not attend, and others were unaware that meetings were taking place again and did not feel they had the opportunity to raise any issues.

2.10 In our survey, only 45% of black and minority ethnic prisoners said that staff treated them with respect, compared with 73% of white prisoners. Prisoners gave examples of discrimination in access to activities and rude staff. The minutes of equality governance meetings suggested that the prison was aware of some of these negative experiences, but actions to explore these concerns had been delayed by staffing and work pressures before the pandemic and further delayed since.

2.11 There was limited support for prisoners who did not speak English, and the prison relied on nationality groups of prisoners to support each other. Although an officer on one wing had started to translate some materials, this was through an internet translation program and was not quality assured.

2.12 Despite significant staff shortages, the chaplaincy remained active in the prison and continued to provide face-to-face pastoral support to prisoners, observing social distancing. Although corporate worship had been suspended, the national prison radio channel broadcast services for prisoners. The chaplaincy responded to individual prisoner requests to attend the chapel. Religious festivals continued to be celebrated. A member of the chaplaincy delivered weekly faith packs to prisoners and bought prayer mats for those who required them. The team had continued to provide core activities, including regular attendance at care in custody and teamwork (ACCT) meetings and supplying information sheets to prisoners due to be released.

Health care

2.13 There was partnership working between the establishment, the main health provider, Public Health England and health commissioners. Incidents and complaints were monitored. However, local governance meetings had ceased and had been replaced by COVID oversight meetings, which did not cover the same range of areas. This structure reduced oversight of emerging risks, such as increasing waiting times for health appointments, health staffing pressures and the cumulative impact of the cessation of some routine health care.

2.14 Health staff were working hard to maintain services for those requiring prioritised care. Access to patients remained restricted due to lockdown requirements. In our survey, most prisoners said it was difficult to get a health care appointment. GP waiting times had

increased from 48 hours to just under two weeks for urgent care, and waiting times for a routine blood test, optician and podiatry were 23 weeks and increasing. (See key concern and recommendation S7.) Social care packages were in place for three prisoners and had been maintained throughout.

2.15 Vacancies, staff shielding and increased workloads had created additional pressures on the primary care and mental health staff. For example, the nurse practitioner was seeing 60% more patients than usual due to the loss of four advanced nurse practitioner days a week. Although patients with some long-term conditions, such as asthma, diabetes and epilepsy, had recent reviews, not all had comprehensive care plans. The waiting time for those requiring an asthma review was also 23 weeks.

2.16 Restoration and recovery plans for health provision were showing early signs of improvement with the imminent return of shielding staff. Staff vacancies and the lack of suitable confidential space to see patients remained problems, although managers had implemented a room-booking procedure to help offset this.

2.17 There was no specified shielding unit or protective isolation unit (see Glossary of terms). However, health care staff were effectively caring for two prisoners on the wing who met the extremely vulnerable shielding criteria (those with specific medical conditions that place them at greatest risk of severe illness from COVID-19). The inpatient unit also held some shielding prisoners who were either physically or mentally unable to shield or socially distance. There were clear arrangements requiring reverse cohorting for new arrivals with symptoms of the virus. There had been nine confirmed COVID-19 cases among prisoners and a small number of staff cases.

2.18 External referrals to hospital had continued but with a reduced attendance rate due to cancellations by both the prison and hospital. There had been a small but increasing number of telephone consultations to mitigate this.

2.19 Medicines had continued to be delivered to prisoners at the hatches with few exceptions. We observed well-supervised and comprehensive medicines administration, although there was inadequate time between the first and third of the daily administrations of medicines to maintain a therapeutic gap. The pharmacist and technician had continued to be present on site during the restrictions.

2.20 Two-thirds of prisoners in our survey declared a mental health problem. Health care staff reported that the number of prisoners seeking mental health support had increased since the prison had initiated the restrictions on the regime; they received an average of 93 referrals a month and were involved with over 200 ACCT reviews in July 2020. This additional need and the restriction on non-urgent appointments had resulted in a waiting list of 16 weeks for routine assessments. The integrated mental health team had, however, managed to assess urgent cases face to face within four days, psychological therapies had been maintained for those already on its caseloads, and those with severe and enduring mental health problems had comprehensive care plans that were reviewed regularly. Eleven prisoners had been identified as requiring a transfer to a secure mental health bed, and all had been held awaiting transfer for longer than the national guidelines. (See key concern and recommendation S7.)

2.21 One hundred prisoners were receiving opiate substitution treatment under the care of a specialist prescriber. Spectrum provided psychosocial support for new and routine assessments as this was not face-to-face work. This support included work packs, self-assessments and general welfare checks through the cell door. In contrast, the 26 prisoners on the recovery wing received face-to-face input, as did those attending the community support hub outside the prison with extensive support through the gate. Some peer mentor-led socially distanced group activity on the recovery unit had recently resumed, which was positive.

Section 3. Purposeful activity

In this section we report mainly on time out of cell; access to the open air; provision of activities; participation in education; and access to library resources and physical exercise.

3.1 Prisoners who were in protective isolation (see Glossary of terms) had only 15 minutes a week out of cell for a shower, which was unacceptable (see paragraph 1.5). Most prisoners spent 22.5 hours a day locked in their cells. They were unlocked for one hour in the open air, six days a week; in addition, each day they had a 30-minute period to shower, clean their cell and make a telephone call; and they collected an evening meal from the servery daily. This arrangement had been in place for around a month; before this most prisoners had been locked up for even longer, in line with the previous nationally applied exceptional regime delivery plan. (See key concern and recommendation S6.)

3.2 Prisoners were allocated morning or afternoon time in the open air depending on their wing location. Unlock times varied on some wings each day, and prisoners found it difficult to adapt to a routine. Prisoners said they could request to make a telephone call at a certain time of the day, but this was not always offered.

3.3 Few prisoners were able to work. There were 97 in employment at the time of our visit, mainly in essential services, such as kitchens, waste management and cleaning. We spoke to some prisoners who were undertaking multiple roles, such as being the allocated wing cleaner and the prison information desk worker, while others were unemployed. The waste management workshop was working at half its capacity to ensure social distancing. All prisoners were paid a minimum weekly wage of £8, including those who had been unemployed before the pandemic and new arrivals. No education classes were being run although education staff were managing distraction packs (see paragraph 3.5).

3.4 The gym remained closed. PE staff were deployed across the prison. We were told a risk assessment had found that exercise sessions in the exercise yard were unviable due to the uneven ground and lack of space. There was no equipment on the exercise yards, and we observed many prisoners sat together with little evidence of staff encouraging them to maintain social distance. Prisoners had been provided with in-cell exercises, but many said it was too hot and uncomfortable to do these indoors (see paragraph 2.5).

3.5 The library was closed but prisoners could request books, although this was limited to one book a week. A range of activity packs were available, including some on different areas of employment and industry, with questions and answers at the back. While prisoners could request these packs, some staff and many prisoners appeared unaware of them.

Section 4. Rehabilitation and release planning

In this section, we report mainly on contact with children and families; sentence progression and risk management; and release planning.

Contact with children and families

4.1 Social visits had been reinstated on 20 July, but were suspended again after five days because of regional restrictions. The social-distancing arrangements in the visits building were robust, but had reduced capacity from 50 to 15 visits per session. Visits had therefore been shortened when available and lasted only 45 minutes. Prisoners who had had visits were dissatisfied with the new arrangements, reporting that the distance between them and their visitors, the requirement to wear face coverings and the quality of the face coverings provided made hearing each other difficult. A visitor survey conducted by the POPS team (Partners of Prisoners, an organisation that provides support to families of offenders) confirmed these perceptions, with more than half of visitors rating the quality of their visit as poor or very poor. Legal visits were still suspended.

4.2 Video calls for prisoners to contact their family or friends had only been introduced on 3 August, following a successful trial week. Most prisoners who had participated were very positive about their experience, and demand was rising. There was capacity for 40 half-hour video calls a day, and prisoners were allowed one video call each month in addition to one social visit.

4.3 As there were no in-cell telephones, prisoners could only use the telephone during their brief periods of unlock. Most could use a telephone regularly, but not always when their family was available to take a call. For example, one prisoner complained that his allocated time had been 8am on a Sunday morning, and others had been given weekday slots when their families were at work. Managers had instructed officers to keep a record of prisoners who had not been able to speak to anyone and to offer another opportunity, but this was not always effective. The prison was not using the mobile telephones provided by HMPPS to offset this problem. (See key concern and recommendation S3.) Prisoners appreciated the £5 telephone credit that they received each week and the fact that call costs had been reduced.

4.4 There was an energetic family liaison team on site, including POPS staff; PACT (Prison Advice and Care Trust) staff were still working remotely. The family liaison team had introduced a new service for prisoners to send and/or receive an electronic photograph each month (subject to public protection restrictions). They had also provided a range of distraction activities for both prisoners and their children.

4.5 Tablet computers had been used on around 14 occasions since the start of the restricted regime to allow prisoner contact with families in exceptional circumstances, such as livestream funerals or to see their newborn children or end-of-life relatives.

4.6 Prisoners could receive correspondence via the 'emailaprisoner' scheme and were also able to reply. Use of this service had increased by around 200% since the restrictions were imposed. There had been no similar increase in the volume of ordinary mail sent or received, even though prisoners were allowed unlimited letters (subject to paying the postage on extras).

Sentence progression and risk management

4.7 The offender management unit (OMU) had sufficient space to maintain social distancing, and most directly employed staff were at work on site. The probation team, community rehabilitation company (CRC) staff and several partner organisations were still working partly from home.

4.8 Prison offender managers only saw prisoners when there were sensitive or complex issues to discuss, such as recalls, public protection arrangements and parole processes. We were told that this was partly to reduce footfall on the wings and partly due to a lack of venues where socially distanced private interviews with prisoners were possible. These constraints applied equally to partner organisations. This lack of contact reduced the effectiveness of much OMU work because prisoners did not know that work on their case was being undertaken. Many prisoners we met were frustrated that they could not easily see OMU or resettlement staff, and in our survey, only 15% of prisoners said that staff were supporting them to achieve their custody plan objectives. (See key concern and recommendation S8.)

4.9 Sentence planning and risk assessment processes were up to date, although most were done without interviewing the prisoner. There was no one-to-one offending behaviour work or supervision. Categorisation decision were prompt but progressive transfers were rare.

4.10 Public protection work had been maintained. The interdepartmental risk management team had continued to meet, but focused exclusively on new arrivals, and its meetings were not currently sufficiently well attended. We were told that multi-agency public protection arrangements (MAPPA) were up to date. Decisions to authorise mail and telephone monitoring were mostly prompt, but telephone monitoring had a five days' delay.

Release planning

4.11 In our survey, only 16% of prisoners due for release in the next three months said they had received support in preparing for release, and many of the prisoners we met were anxious about what would happen to them on their release.

4.12 The CRC team had innovated to find ways of delivering assessments, even during the first month of restrictions when they were working entirely remotely. They now invited prisoners to contribute remotely to their assessment or resettlement plan review by completing a paper questionnaire. However, not all prisoners did so and this was not an adequate substitute for direct contact.

4.13 The CRC made referrals to resettlement support services as necessary, but because some service providers were working remotely or at reduced capacity, some prisoner needs were not met in custody. For example, lower level mental health needs were not always assessed (see paragraph 2.20). We saw evidence of some effective communication by the CRC with community offender managers to help ensure prisoner needs were met after release.

4.14 Home detention curfew processes were operating effectively and did not appear to have been compromised by the pandemic restrictions.

4.15 Shelter was contracted by the prison to provide housing support services, and had worked with local authorities and the government's Homelessness Prevention Taskforce to ensure that every prisoner had accommodation on release. Sometimes this was only secured on the day of release and was in a hotel, but prisoners were referred to agencies who could help them find longer term accommodation. Finance, benefit and debt interventions had not been prioritised when staff were working remotely, but had substantially recovered by June 2020.

4.16 No prisoners had been discharged under the end of custody temporary release scheme (see Glossary of terms) or compassionate release on temporary licence, although over 80 had been considered.

4.17 On release, staff provided prisoners with face coverings and explained when they needed to be worn. Health care staff provided a month's supply of prescribed medication where needed, and the CRC provided a mobile telephone for any prisoners who needed to make telephone calls to secure accommodation. Prisoners received a discharge pack which contained a range of useful documentation. Prisoners could report to the Community Engagement Centre outside the prison after release, where a range of ongoing support and resources were available.

Section 5. Appendices

Appendix I: Scrutiny visit team

Martin Lomas	Deputy Chief Inspector
Hindpal Singh Bhui	Team leader
Hayley Edwards	Inspector
Jeanette Hall	Inspector
Rebecca Mavin	Inspector
Tamara Pattinson	Inspector
Tania Osbourne	Health care inspector
Helen Ranns	Researcher
Shannon Sahni	Researcher

Section 6. Further resources

Some further resources that should be read alongside this report have been published with it on the HMI Prisons website. For this report, these are:

Prisoner survey methodology and results

A representative survey of prisoners is carried out at the start of the scrutiny visit, the results of which contribute to our evidence base for the visit. A document with information about the methodology, the survey and the results, and comparisons between the results for different groups are published alongside the report on our website.

Staff survey methodology and results

A survey of staff is carried out at the start of every scrutiny visit, the results of which contribute to the evidence base for the visit. A document with information about the methodology, the survey and the results are published alongside the report on our website.