Report on a scrutiny visit to

HMP Leicester

by HM Chief Inspector of Prisons

8 and 15-16 December 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 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/

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. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence.

Key worker scheme
The key worker scheme operates across the closed male estate and is one element of the Offender Management in Custody (OMiC) model. All prison officers have a caseload of around six prisoners. The aim is to enable staff to develop constructive, motivational relationships with prisoners, which can support and encourage them to work towards positive rehabilitative goals.

Personal protective equipment (PPE)
Safety equipment including masks, aprons and gloves, worn by frontline workers during the COVID-19 pandemic.

Purple Visits
A secure video-calling system commissioned by HM Prison and Probation Service (HMPPS). This system requires users to download an app to their phone or computer. Before a visit can be booked, users must upload valid ID.

Recovery plan
Recovery plans are published by HMPPS and aim to ensure consistency in decision-making by governors, by setting out the requirements that must be met for prisons to move from the most restricted regime (4) to the least (1) as they ease COVID-19 restrictions.

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

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

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).

Introduction

This report presents the findings from our scrutiny visit to HMP Leicester on the conditions and treatment of prisoners during the COVID-19 pandemic. HMP Leicester is a small and ageing city-centre, local prison which opened in 1828. There were 294 prisoners at the time of our visit, slightly less than the operating capacity, but many more than the prison was designed for. Some areas of the prison were cramped and social distancing was a challenge for staff and prisoners. In areas such as wing offices, we frequently observed several staff gathered with little regard to maintaining a safe distance.

There had been welcome investment to improve conditions at the prison before the COVID-19 crisis. Improvements to communal showers were appreciated by prisoners and the planned introduction of in-cell telephones in early 2021 will help them to maintain family contact. The recent installation of a body scanner helped to combat illicit items.

The prison had a high turnover and had continued to serve the courts and manage many short-term sentences throughout the pandemic. The challenges faced by the prison were compounded by the high rates of COVID-19 in the city and the local lockdown that had been in place since the summer.

In March 2020, several prison staff had been absent with COVID-19 symptoms and in April 2020 a prisoner with COVID-19 symptoms had died. The senior management team had taken swift action to implement quarantine and shielding arrangements shortly before the imposition of national restrictions. This had helped to keep prisoners safe from the spread of infection and there had been just eight known positive tests among prisoners since March, with the last recorded case in October.

It was acknowledged that the severely curtailed regime at the start of the pandemic was sensible to keep people safe, but 10 months later a very cautious approach remained and progress towards recovery was slow. Limited improvement in some areas had been hampered further by the second national lockdown shortly before our visit.

Oversight of areas such as safety had continued during the pandemic and the focus on the imminent risk of COVID-19 spreading in the prison was understandable. Many strategic meetings had been suspended soon after restrictions were introduced, though some key meetings such as equality and diversity had restarted during the summer but were not yet fully functioning. There had been no formal oversight of segregation procedures during 2020, which was concerning.

Arrangements had been made to make sure that reception procedures minimised the risk of transmission of the virus. COVID-19 testing was now routinely offered to all arriving prisoners and a programme had recently been implemented to offer staff testing. Some aspects of early days arrangements lacked adequate oversight by staff and time out of cell for those on the reverse cohort unit was very limited, especially at weekends.

Recorded incidents of violence and use of force had reduced during the pandemic. Prison managers attributed this to a combination of the restricted regime and positive staff-prisoner relationships. In contrast, reported incidents of self-harm had remained high compared to similar prisons and one in five prisoners who responded to our survey said that they felt unsafe.

The use of the Lambert unit lacked clarity. During the restricted regime it had been used for prisoners with complex mental health needs and those with challenging behaviour, which were incompatible. We witnessed a prisoner being given an unofficial punishment following an outburst towards staff. The Lambert unit and segregation unit lacked strategic governance to make sure they were used appropriately.

Most interactions between staff and prisoners were positive, but formal, structured key worker sessions remained suspended. Prisoners who were identified as vulnerable received a daily welfare check, though these were too superficial to identify emerging issues. Senior managers were often visible during the day, but formal communication with prisoners was largely limited to printed material and there had been no consultation forums since March.

Many cells were cold with little natural light and this was even more pronounced on the prison's subterranean level. Not all cells were adequately equipped and access to clothing was a concern, for example, prisoners were only issued with two pairs of underpants a week.

In our survey, only 47% of prisoners said that health services were good. Despite this, we found that the health providers had worked well to help manage the risk of infection and were well prepared for any future outbreak. The regime restrictions and social distancing requirements had reduced access to some aspects of health care, but waiting lists for most services had been reduced. The use of a dedicated health care assistant for prompt assessment of social care needs and mental health support on release was a positive initiative.

The regime was consistent for most prisoners, but it remained severely limited and there had been very little improvement since March. Most prisoners had at most 50 minutes out of cell, including 30 minutes in the open air. The library had continued to operate, but access was limited, and the ordering system was not robust for prisoners who could not attend. The recent introduction of classroom-based education for a small number of prisoners was encouraging, but too many remained locked in their cells with little meaningful activity. The gym facilities had remained closed since March, despite work by staff to plan for the reintroduction of COVID-19 secure indoor PE.

The ability of prisoners to maintain contact with their children and families had been limited throughout the restricted regime. Social visits had not restarted until October and had then been further curtailed to reflect national restrictions. Actions taken following an infringement of physical contact between a prisoner and his child were disproportionate and lacked compassion. The absence of face-to-face family support work also affected family engagement.

Most prisoners had an up-to-date assessment of their risks and needs, but the quality of offender management had been undermined by the lack of face-to-face contact. There was an over-reliance on a self-reporting questionnaire or outdated information to complete assessments. The lack of direct contact had also affected the quality of resettlement planning for the large number of prisoners released from Leicester. The introduction of a well-used, direct phone line for prisoners to contact the offender management unit and resettlement teams was a positive intervention to address some of these concerns.

Managers, staff and prisoners had responded well to the early stages of the pandemic with a focus on reducing the risk of transmission and maintaining an environment safe from COVID-19. The continuing local community restrictions had understandably affected some aspects of recovery, but progress had been slow in re-introducing key strategic meetings and consultations with prisoners. More focus was needed on reducing the high levels of self-harm. The reduction in violence was welcome, but an emergency restricted regime is not a long-term solution to keeping prisoners safe and strategic planning will be needed to maintain any improvement when recovery from the pandemic gathers pace.

Charlie Taylor
HM Chief Inspector of Prisons
December 2020

Fact page

Task of the establishment
HMP Leicester is a local adult male prison, supporting the courts of Leicester and Leicestershire, holding prisoners on remand as well as those sentenced, typically for resettlement purposes.

Certified normal accommodation and operational capacity (see Glossary of terms)
Prisoners held at the time of this visit: 294
Baseline certified normal capacity: 214
In-use certified normal capacity: 217
Operational capacity: 300

Prison status (public or private) and key providers
Public

Physical health provider: Nottinghamshire Health Care NHS Foundation Trust
Mental health provider: Nottinghamshire Health Care NHS Foundation Trust
Substance use treatment provider: Turning Point
Prison education framework provider: People Plus
Community rehabilitation company (CRC): Derbyshire, Leicestershire and Rutland CRC
Escort contractor: GeoAmey

Prison group/Department
East Midlands

Brief history
HMP Leicester is a Victorian prison built in 1874, behind a gatehouse dating back to 1825. It occupies a site of three acres, close to Leicester city centre. A visits and administration block was added in 1990.

Short description of residential units
HMP Leicester is predominantly made up of one large residential wing, separated into landings and units.
Landing 1: (subterranean) the Parson's Unit (enhanced/workers'), Lambert Unit (re-integration) and segregation.
Landing 2: mainstream population with the shielding unit attached.
Landing 3: mainstream population and the reverse cohort unit.
Landing 4: mainstream population, prisoner isolation unit and additional reverse cohort unit spaces.
Welford Unit: prisoners convicted of sexual offences and vulnerable prisoners.

Name of governor and date in post
Jim Donaldson, November 2018

Independent Monitoring Board chair
Irene Peat

Date of last inspection
January 2018

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 21 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 number of key recommendations for the prison to address.

S3 **Key concern:** The Lambert unit was intended to provide a more focused approach for prisoners who needed additional support and care. In reality, the unit appeared to be an extension of or alternative to segregation and the unit lacked clear purpose. Prisoners with complex mental health needs, challenging and violent behaviour and those leaving segregation were all housed on the unit. Some prisoners were awarded unofficial punishments by staff, including further restrictions to their regime.

Key recommendation: The purpose of the Lambert unit should be clearly defined, and robust oversight should ensure appropriate use of the unit, segregation and special accommodation, and effective reintegration planning. (To the governor)

S4 **Key concern:** The living conditions remained poor and not all prisoners lived in a clean, decent environment. Too many prisoners were held in overcrowded conditions in cells with little natural light that remained cold even when additional heaters had been provided. Many cells containing two prisoners did not have enough privacy screening round the toilet and lacked lockable cabinets. Most prisoners were unable to shower each day and were not issued with enough clean clothes or a coat to wear in the winter.

Key recommendation: All prisoners should be able to live in a clean and decent environment.
(To the governor)

S5 **Key concern:** Work to promote equality remained weak. There were no accurate data on prisoners with protected characteristics and no systematic consultations with prisoner groups. There was little evidence that the prison collected and analysed data to identify potentially disproportionate outcomes for groups of prisoners. Actions at the equality action team meetings were not progressed quickly. Two designated equality posts had been vacant for more than six months. The responses to discrimination incident report forms did not address adequately complaints of discrimination.

Key recommendation: The needs of prisoners with protected characteristics should be identified and addressed.
(To the governor)

S6 **Key concern:** Patients requiring assessment and treatment in mental health hospitals waited excessive times to progress, despite our recommendation in 2018. At the time of our visit, five patients had waited between 21 and 266 days to be transferred, which was unacceptable.

Key recommendation: Patients requiring assessment and treatment in mental health hospitals should be transferred expeditiously, and within the Department of Health target transfer time. (To the HMP Leicester health partnership board)

S7 **Key concern:** Time out of cell for prisoners was inadequate. Most prisoners had at most 50 minutes to complete daily tasks and take exercise, with even less time from Friday to Sunday. Workers had more time out of cell, but three-quarters of the population remained unemployed. Prisoners who spent more than 23 hours a day in their cells had little to occupy them, group therapies had been halted and health clinics were under-used.

Key recommendation: Prisoners should have adequate time out of their cell each day to promote health and mental well-being.
(To the governor)

S8 **Key concern:** The ability of prisoners to maintain contact with their families was very limited. There were no social visits and no face-to-face family support work. Video calling was limited to one 30-minute call a month. Some prisoners had not been able to see their children and families for more than nine months and told us that this was adversely affecting their mental health and well-being.

Key recommendation: Prisoners who are not subject to any associated public protection restrictions should be able to re-establish and maintain relationships with their children and families.
(To the governor)

S9 **Key concern:** Many prisoners had not received face-to-face support from the offender management unit and resettlement team for the last 10 months. Assessments of prisoners' risks and needs were often completed without speaking to the prisoner or were based on outdated assessments. Resettlement plans were only reviewed using the internal mail. The importance of face-to-face contact to identify risks, behaviours and changes in circumstances was not recognised.

Recommendation: Prisoners should have face-to-face contact with their offender manager and resettlement worker to ensure that their risks are appropriately managed and their needs met.
(To the governor**)**

Notable positive practice

S10 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.

S11 Inspectors found the following examples of notable positive practice during this visit.

- A health care assistant, funded by the local authority and dedicated to social care, provided rapid assessment of and responses to physical disabilities among the prisoners. (See paragraph 2.18)

- The new mental health CTI (critical time interventions) team ensured that patients being released from the prison were supported before leaving and for up to six weeks after release. This helped to cement their relationships with the services they needed at a vulnerable time. (See paragraph 2.36)

- A prisoner who had difficulty reading had been supplied with a reading pen to scan text and convert it to audio to enable the prisoner to engage with education. (See paragraph 3.7)

- Astro-turf had been installed and gazebos erected in the exercise yard to encourage prisoners to engage in physical exercise during bad weather. (See paragraph 3.8)

- A direct phoneline had been introduced for prisoners to call several key departments including the offender management unit. This service was well used and prisoners told us that they valued receiving quick responses to their concerns. (See paragraph 4.11)

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 One prisoner had died from a COVID-19 related illness and a significant number of prison staff had been absent with symptoms in March when knowledge of the virus and requirements for personal protective equipment (PPE, see Glossary of terms) were limited. The management team had responded promptly to these early concerns and started quarantine and shielding arrangements (see Glossary of terms) before national restrictions were introduced. These measures had helped to keep prisoners and staff safe from the virus and only eight prisoners had tested positive since March.

1.2 The prison had continued to follow national guidance to control the risk of infection. Signage throughout the prison highlighted the importance of social distancing but, as in other prisons, the restricted space in some communal areas made this difficult. In our staff survey, all frontline operational staff who responded said that it was difficult to adhere to social distancing from colleagues and 85% said it was difficult to maintain social distance from prisoners. Despite this, we frequently observed several staff gathered in areas such as wing offices with little regard to maintaining a safe distance. There were adequate stocks of PPE and we observed good adherence by staff to the use of face coverings. Hand sanitisation stations were accessible in all areas of the prison.

1.3 Communication with staff had been effective and senior managers attended a daily briefing for staff. In our survey, 87% of staff who responded understood what was expected of them. While 85% of staff who responded said they had felt supported during the crisis, just under half said that their morale had declined.

1.4 Most prisoners who responded to our survey (78%) understood the restrictions that were in place and 86% said that the reasons for such measures had been explained to them. Communication with prisoners was limited mainly to written notices and a weekly newsletter.

1.5 Managers were visible on the residential units at key times during the day, but formal consultation had not taken place since March. The lack of formal consultation to understand the views and needs of prisoners was exacerbated by the absence of meaningful contact with prisoners through key work (see Glossary of terms) or other initiatives. Positive staff-prisoner relationships mitigated these concerns to some extent.

1.6 The governor had clearly prioritised management of the pandemic and its impact, but steps towards recovery remained cautious and strategic oversight in some areas had declined. For example, there had been no formal governance of segregation since the start of the year and work to promote equality and diversity had only restarted in the late summer.

1.7 This cautious approach combined with restrictions in the local community had led to slow progress with the prison's recovery plans (see Glossary of terms). There had been very little change to the regime over the previous 10 months. Planning for progress to a less restrictive regime when the spread of the virus was reduced was limited.

1.8 There was not enough in-cell activity and time out of cell was severely restricted to less than 50 minutes a day for most prisoners, with even less for many prisoners at weekends (see paragraph 3.1). Capital investment had been provided to improve the showers, but otherwise living conditions had been neglected. It was also concerning that we found examples of unofficial punishments (see paragraph 1.25).

Arrival and early days

1.9 Measures taken in reception ensured that the risk of transmission of the virus was limited. Temperature tests were taken on arrival by a nurse and face masks distributed before prisoners alighted from the escort vehicle. Holding rooms had reduced capacity to enable social distancing, hot drinks were provided in a take-away cup and hand sanitiser was available.

1.10 The reception building was small, limited in its use and in need of renovation. Toilets were dirty and holding rooms bare (see Appendix II). The television in the main holding room was broken and no information was given to prisoners while they were waiting. We were told that funding had been agreed to make general improvements to the building.

1.11 Prison officers conducted brief first night interviews in private. Protected characteristic groups were not identified during this process (see paragraph 2.15). Other prisoners were used to interpret for non-English-speaking prisoners, which was not appropriate for confidential information.

1.12 Induction was delivered face to face by a peer adviser while social distancing was maintained, which was positive. Printed handouts were also provided. The induction programme included information about the current regime and general rules and procedures. The peer worker also collated sensitive information such as housing needs, finance, benefits and debt, which was not appropriate. There was no staff oversight to ensure that the induction was suitable and delivered consistently.

1.13 New arrivals were allocated to the reverse cohort units (RCU, see Glossary of terms). Nearly all prisoners could shower and make a phone call on their first night and additional welfare checks were completed during the first 24 hours.

1.14 The communal areas of the wing were reasonably clean, but cells were dirty and cramped (see paragraph 2.5). An essentials pack containing basic toiletries was provided for new arrivals.

1.15 Cohorting arrangements on the RCU were reasonably well managed but the regime was not adequate. Prisoners were placed into 'bubbles' according to their day of arrival. Prisoners were unlocked in pairs from their allocated 'bubble' with 20 minutes offered for a shower and a phone call. This was offered each day, but time in the open air was limited to 30 minutes five days a week.

1.16 The recent introduction of COVID-19 testing for new arrivals had reduced the time spent on the RCU and was a welcome initiative.

Managing behaviour

1.17 In our survey, one in five prisoners said they felt unsafe which was similar to our full inspection in 2018. Just under a third said they had been victimised by staff.

1.18 Recorded levels of violence and use of force had reduced during the restricted regime, although there had been an increase in violence, use of force and self-harm during the previous six weeks. Managers attributed the earlier reduction to a combination of reduced time out of cell and positive relationships. There was no strategy to sustain the reduction in violence when restrictions were lifted.

1.19 Regular safety intervention meetings led by managers had continued throughout the restricted regime to discuss and manage complex prisoners with high levels of need. The meetings were well attended. Records indicated that actions to support prisoners were monitored at each meeting and there was evidence of improved practice. The safety improvement plan had not been updated for some time and was not discussed at these meetings, which was a missed opportunity.

1.20 The volume of security intelligence reports had reduced since restrictions were imposed. Intelligence was analysed effectively and there were few backlogs. The intelligence was used at security meetings to address emerging risks, such as the ingress of illicit items. The prison had recently sourced a body scanner and a Rapiscan itemiser (an electronic device used to detect and identify illicit substances) to disrupt the supply of illicit items further. They had so far proved beneficial.

1.21 Challenge, support, and intervention plans (CSIPs, see Glossary of terms) were used reasonably well to manage the perpetrators of violence. Investigations were prompt and only three were outstanding at the time of our visit. Despite this, support for victims of violence or those who were in debt was underdeveloped and some were left with little formal support.

1.22 The number of recorded incidents of force was lower than the previous year but had remained consistent since the introduction of the restricted regime. Very few incidents resulted in full restraint. Governance had continued and training had been reintroduced to focus on areas of identified concern such as the use of body-worn video cameras.

1.23 At the start of the restricted regime, all prisoners had been removed from the lowest level of the incentives scheme in line with HM Prison and Probation Service (HMPPS) guidance. Progression to the highest level of the scheme was limited because the regime made it difficult for prisoners to demonstrate improved behaviour. Prisoners on the enhanced level were able to buy a Freeview box to access additional television channels in their cell.

1.24 Segregation remained an old and worn landing below ground level in the main residential wing. The regime was limited to a daily shower, telephone call and open-air exercise on a very small yard. Data on the use of segregation and special accommodation were still collated, but there had been no strategic oversight meetings during 2020. We were concerned that this absence of governance and management oversight left the appropriate use of segregation and special accommodation unmonitored.

1.25 We were given different accounts for the function of Lambert unit which was based on the same subterranean floor as the segregation unit, separated by a gate. Senior managers told us it was a dedicated unit with staff who had received bespoke 'Timewise' training (a short cognitive skills programme which aims to reduce violence in prison) to deliver a more focused approach to prisoners requiring additional support and care. Our observations and discussions with staff and prisoners indicated that the unit was an extension of and alternative to segregation. The unit had been used for incompatible purposes during the restricted regime. Prisoners with complex mental health needs or challenging and violent behaviours and those leaving segregation were all housed on the Lambert unit. There was no strategy for allocating prisoners based on need and there was inconsistent use of re-integration plans for prisoners on Lambert unit and in segregation (see key concern and recommendation S3). We observed a prisoner being denied access to a shower and exercise

by staff without authority, which constituted an unofficial punishment. Our concerns were addressed by senior managers on the same day, but we were not confident that use of the unit was appropriate without effective strategy or governance.

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

1.26 There had been no self-inflicted deaths in custody during 2020 and three during 2019, one of which took place the day after the prisoner's release. A death in custody action plan was not drawn up until after the recommendations of the Prisons and Probation Ombudsman had been received. Once the action plan had been formulated, the completion of recommendations was monitored, although we noted that some actions identified as complete were not. For example, one recommendation that risk reduction plans should be specific, meaningful and tailored to the individual's risk had not been addressed.

1.27 The number of self-harm incidents had remained high throughout the restricted regime, although there had been several fluctuations. Prison managers had conducted effective analysis and had been able to identify the reasons for the changes. It was not clear if action was being taken to identify weaknesses or to reduce self-harm.

1.28 In our survey, 57% of prisoners on an ACCT (assessment, care in custody and teamwork case management of prisoners at risk of suicide or self-harm) review said they felt cared for by staff. The ACCT documentation that we reviewed was reasonable. Case reviews included attendance by the mental health team. Many care plans were too generic with vague targets and limited positive outcomes.

1.29 Prisoners who isolated themselves from their peers, usually because they felt vulnerable, were identified and monitored through the safety intervention meetings. We were told that these prisoners received daily welfare checks and additional support from the safer custody team. Nevertheless, more was required by the prison to understand and address the underlying issues that led to a small number of prisoners wishing to self-isolate.

1.30 Important peer support schemes such as the Listeners (prisoners providing emotional support to fellow prisoners) had ceased during the regime restrictions due to limited numbers. It was positive that the prison had recently facilitated a training programme to increase the number of Listeners in a bid to resume this essential service.

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 Staff-prisoner relationships at Leicester were really positive. In our survey, 85% of prisoners said most staff treated them with respect, and 78% said there was a member of staff they could turn to if they had a problem. We observed many positive interactions, and many prisoners spoke well of their wing staff.

2.2 There was limited evidence of more structured, supportive dialogue with prisoners. Formal key work had ceased at the start of restrictions, and daily checks had been introduced for prisoners identified as more vulnerable. In our survey, less than half the respondents said that a member of staff had spoken to them in the last week to ask how they were getting on.

2.3 Electronic case note records of these welfare checks frequently consisted of just three closed questions asking prisoners if they felt all right, did they need any help or anyone to talk to. Prisoners told us that these checks were perfunctory and did not represent meaningful contact.

Living conditions

2.4 Most prisoners were located on a single wing over four levels. The age, design and construction of the wing led to many cells being cold with little natural light. This was even more pronounced on the underground level. Managers had tried to address this by supplying plug-in heaters in most cells to supplement the main heating system, but this had not been effective (see key concern and recommendation S4).

2.5 About half the single cells on the main wing housed two prisoners in cramped conditions. Many of these cells lacked a lockable cupboard to secure personal items such as in-possession medication (see Appendix II). Many cells did not have enough privacy screening round the toilet. For example, a transgender prisoner was in the Lambert unit in a cell with no screening and the cell lacked an additional heater.

2.6 We saw wing cleaners working and communal areas, including showers, were generally clean. The prison had tried to eradicate the problem of cockroaches, but many prisoners complained to us about them.

2.7 In our survey, only 69% of respondents said they could shower every day because of their limited time out of cell. Most prisoners had an opportunity to shower from Monday to Thursday, but only every other Friday and one day each weekend.

2.8 Many prisoners told us that they were not issued with enough clothes. Each prisoner was issued with a tracksuit, a towel and two pairs of socks and underpants each week. Prisoners were not routinely provided with coats to wear during the limited time in the open air. Many prisoners resorted to washing kit in their cells and hanging them in the cramped space. The lack of laundry facilities deterred many from wearing their own clothes (see key concern and recommendation S4).

Complaints, legal services, prisoner consultation and food and shop

2.9 The regular prison council consultation meetings with prisoners had stopped when COVID-19 restrictions were imposed. Managers were visible and willing to engage with prisoners during the day, but this did not replace formal consultation. We were told that consultation was difficult because of lack of space and the need for social distancing. A number of key functions had continued, including the training of Listeners (see paragraph 1.30), and there was scope to reinstate formal consultation meetings.

2.10 The prison had conducted a survey of some prisoners in May, but there was no evidence since then of structured work to understand the needs of the population. There were no wing-based peer representatives other than on the reverse cohort units (RCU, see Glossary of terms).

2.11 Some prisoners told us that when they submitted paper-based applications they did not receive a response or even an acknowledgement. A facility had been introduced for prisoners to use their PIN phones to make direct contact with departments such as education and the offender management unit (see paragraph 3.7). This was a well-used facility and mitigated some of the frustration faced by prisoners.

2.12 The number of complaints had reduced during the restrictions compared to the previous year and, in our survey, 59% of respondents said it was easy to make a complaint. Oversight and quality assurance of complaints were reasonable. Most of the responses that we looked at indicated that timeliness and actions taken were adequate although, in some cases where the complaint had suggested discrimination, this had not been fully investigated (see paragraph 2.20).

2.13 In our survey, 74% of respondents said the food was good or reasonable, and our observations confirmed this.

Equality, diversity and faith

2.14 Equality and diversity had not been promoted adequately throughout the year. The equality action team had resumed meetings in July and data provided by the regional equality team were analysed. The minutes did not track the actions raised, some of which were not carried forward to the next meeting and took many months to complete.

2.15 There was little evidence that data were collected and analysed from key areas such as the segregation unit to identify potentially disproportionate treatment among prisoner groups. Two key posts to support the delivery of equality work had remained vacant for more than six months. The updates provided by senior managers to the equality action team were limited, with little evidence of any proactive work (see key concern and recommendation S5).

2.16 The prison still did not fully understand the range of protected characteristics in the population, for example we spoke to two prisoners, known by wing staff to be gay and bisexual, whose sexuality had not been recorded correctly.

2.17 A safety survey had been distributed to black, Asian and minority ethnic prisoners, but there had been no structured consultation with prisoners with protected characteristics. Five peer equality representatives had recently been trained and appointed to help improve consultation with protected groups.

2.18 Some older, less mobile prisoners resided on the Welford unit on the floors above health care, which provided more spacious accommodation and accessible showers. The two prisoners in receipt of a social care package (see Glossary of terms) received good support and the use of a designated care assistant to deliver rapid assessment was good practice (see paragraph 2.30).

2.19 There was no specific support for the large population of foreign national prisoners. We saw interpreting services being used at reception, but there was no monitoring of the use of these services.

2.20 Thirteen discrimination incident report forms (DIRFs) had been submitted since March. In addition, several general complaints which had indicated potential discrimination had not been investigated. All DIRFs were subject to internal quality assurance and a small number were scrutinised by the independent monitoring board. Some responses were unreasonably delayed, and most replies were impersonal. None of the DIRFs had been upheld, but the investigations were not always thorough enough to determine if any should have been supported and acted on (see key concern and recommendation S5).

2.21 The chaplaincy was visible and continued to provide good spiritual and pastoral support. Many prisoners spoke highly of this. Communal worship remained suspended, but the chaplaincy personally distributed in-cell faith material to about 200 prisoners each week.

2.22 Some small faith groups had restarted, but it was disappointing that the 'DistrACCTion' meetings had not resumed. These meetings provided additional support for an hour each week in a relaxed environment away from the main wing for prisoners who were on open assessment, care in custody and teamwork case management of prisoners at risk of suicide or self-harm reviews (ACCTs), self-isolating or deemed to be coping less well.

Health care

2.23 The effectiveness of partnership working between the prison and health care providers, with advice from Public Health England, had been tested early in the pandemic. In March, when staff numbers were seriously depleted because of staff sickness, self-isolation and shielding (see Glossary of terms), the outbreak was well managed.

2.24 Eight patients had tested positive for coronavirus since March. The prison and health care providers were prepared to manage the population safely with joint recovery plans (see Glossary of terms) and risk assessments. There was good awareness among staff members, and plentiful supplies of appropriate personal protective equipment (PPE, see Glossary of terms). Other potentially infectious diseases such as tuberculosis had been appropriately managed during the pandemic.

2.25 Nottinghamshire Health Care NHS Foundation Trust delivered primary care supported by Inclusion Healthcare GPs and visiting specialists who delivered clinics. New prisoners were screened and tested for COVID-19 and existing prisoners could access health care easily if they had concerns. In our survey, 59% of prisoners said it was easy to see a nurse.

2.26 Before the outbreak of the pandemic, the workload in the health centre had been reduced by delivering more consultations on the wings so that refurbishment work could be carried out in the health centre. This had enabled a smooth response to the ensuing restrictions. During the pandemic, further developments included technological innovations such as laptop computers to connect to health care remotely, and telephone consultations with the GPs and hospital. These initiatives had supported patients during the restrictions.

2.27 Clinics had been suspended in March, but most health personnel continued to attend the prison to offer emergency support and triage. Some clinics had resumed in the summer and specialist clinics in September. The capacity of health care was underused, with clinic lists short because of regime restrictions and social distancing. It was rare for a patient to miss an appointment.

2.28 Waiting times had been reduced and were similar to those in February, for example 28 men were waiting an average of four weeks to see an optometrist, seven for up to four weeks for physiotherapy, and seven up to six weeks for podiatry. The GP and other prescribers were available on the day if need was urgent. Care of long-term conditions was good and patients were advised of the risks associated with their conditions posed by COVID-19.

2.29 Time for Teeth had continued to deliver dental triage and some emergency treatments throughout the restrictions. In common with other prisons, aerosol generating procedures had been suspended in March, restarted in the summer, stopped again in August and not resumed until December while prison officers were trained to use battery-powered respirators. Waiting lists had increased as a result after reducing in the summer and only 11% of prisoners in our survey said it was easy to see the dentist. At the time of our visit, 17 patients were waiting no more than four weeks to start non-urgent treatments.

2.30 Social care provision had improved when Leicestershire City Council had become fully engaged in 2018. The Council had funded a suitably trained care assistant to provide rapid assessment and response to physical disability needs. Twenty-seven patients had been assessed since April and two were in receipt of social care packages (see Glossary of terms).

2.31 Nottinghamshire Healthcare Trust had an open referral system for mental health assessments which included scanning the daily prison reports and ACCT reviews to identify prisoners who might need support. Patient numbers had fluctuated little in 2020, with about 135 receiving mental health services. Services had improved with a more diverse range of psychological therapies, wider competences among staff and a developing neuro-disability pathway.

2.32 Face-to-face mental health and substance misuse therapies had been halted in March and restarted in June, but therapeutic groups had not yet restarted.

2.33 Patients still waited too long for transfer to mental health hospitals. All five patients on the transfer waiting list at the time of our visit were beyond the transfer time target (14 days), one of whom had waited more than 100 days and one more than 250 days. This was unacceptable (see key concern and recommendation S6).

2.34 Turning Point workers triaged all new prisoners to identify substance misuse needs. They had adapted their approach to ensure support for 110 patients in their care by converting group materials into in-cell work packs, providing welfare checks and support at cell doors and, from July, finding confidential and safe spaces to meet patients on the wings. At the time of our visit, 55 patients were in receipt of opiate substitution therapy. Administration of the therapy was adept and the queue was well supervised.

2.35 Pharmacy services were professional and efficient. Developments in medicines management, including increased staffing and relocation of the administration hatches, had restarted after being temporarily halted by COVID-19. A large number of the population (85%) were in receipt of medicines, 166 of whom had medicines in possession with up-to-date risk assessments. Only 12 patients were in receipt of divertible medicines and uptake of free vitamin D from the canteen was suitably monitored by health care.

2.36 Patients leaving the prison were given treatment summaries for their GPs, medicines to take home as necessary, and advice on how to minimise the risks of contracting COVID-19.

Harm minimisation advice from Turning Point was complemented by naloxone (to reverse the effects of opiates) for prisoners who would benefit. Mental health practitioners delivered innovative 'critical time interventions' (CTIs) to patients so that through-the-gate support continued for six weeks after release to ensure engagement with services. CTIs had successfully supported 33 of 35 prisoners released during 2020, six of whom had a history of relapse and committed a further offence or were admitted to hospital shortly after release.

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 Time out of cell had remained severely restricted since March. Most prisoners had at most 50 minutes to complete their daily tasks and take exercise. Even less time was available from Friday to Sunday (see key concern and recommendation S7). Many prisoners told us that this prolonged period of isolation had had a negative impact on their mental well-being. One said: 'I'm at the point I can't be in my cell 24/7 and I'm starting to feel suicidal and can't stop thinking I don't want to be here anymore.'

3.2 There was little communal space on the main unit and only one main exercise yard, but several rooms, such as the former drug treatment waiting and visits room, were often empty. There was no evidence that options had been explored to increase the time out of cell. Other areas including access to therapy groups and health clinics had also been affected (see paragraph 2.27).

3.3 One workshop had been in operation before the pandemic, but this remained closed. There were no plans to reopen the workshop, which was disappointing.

3.4 Early in 2020 almost 40% of the population had been in employment. At the time of our visit, this had reduced to 25% and, in our survey, 60% of respondents said it was difficult to get a prison job.

3.5 The remaining three-quarters of the population who were unemployed were in their cells for more than 23 hours a day with little to fill their time other than weekly distraction packs. In our survey, only half of those who had received packs had found them useful (see key concern and recommendation S7).

3.6 Classroom-based education had recently been reintroduced for a small number of prisoners attending a cleaning course, which was positive. A financial incentive encouraged prisoners to engage with in-cell education, and in the previous three months 63 prisoners had completed 80 different courses, some comprising several workbooks. A further 106 courses were in progress.

3.7 Prisoners were able to phone the education department directly from their PIN phones for support (see paragraph 2.11). This was a positive initiative which helped individual prisoners. Coloured screens had been provided for a prisoner with dyslexia and a prisoner who had difficulty reading was given a 'reading pen' to scan text and convert it to speech, which had allowed him to engage with education.

3.8 The gym remained closed, although PE staff were proactive and were ready to re-commence indoor PE with appropriate social distancing in place; prisoners had been encouraged to exercise outdoors. Astro-turf had been laid and gazebos erected so that exercise could continue in bad weather, which was good practice (see Appendix II).

3.9 The library had continued to operate on a very limited basis throughout the period of restrictions. However, prisoners who were not located on the main wing were not able to visit and the ordering system was not robust enough to meet need.

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 The ability of prisoners to maintain contact with their children and families had been limited throughout the pandemic. Restricted social visits had been reinstated in October, later than other prisons, but had been curtailed again after two weeks to reflect national restrictions. When visits were permitted, no physical contact between prisoners and visitors had been allowed, visitors were required to wear face masks and to be from the same household. The capacity of the visits hall had been reduced to allow for social distancing and the uptake of visits had been relatively low during the brief re-introduction. The number of visits prisoners could receive had reduced to one visit every two months (see key concern and recommendation S8).

4.2 There had been one breach of physical contact restrictions when a prisoner had allowed his six-year-old daughter to sit on his knee. The response had been excessive. The prisoner had been placed on an adjudication, placed on banned visits for three months and both he and his cell mate were placed in isolation on the RCU. This response was disproportionate to the risks presented.

4.3 At the time of our visit, prisoners did not have access to in-cell telephones, but there were advanced plans to install them in 2021. Landing phones were available, but calls had to be made quickly because of the limited time out of cell (see paragraph 3.1). This was mitigated by good access to HM Prison and Probation Service (HMPPS) mobile phones which had been supplied for prisoners to make calls from their cells. This service was well used and 84% of prisoners in our survey said they had been able to use a phone every day. However, half the mobile phones had gone missing or had been damaged. Procedures to ensure that prisoners with public protection concerns did not have access to the phones were not always robust enough. The prison rectified this during our visit.

4.4 Video calling was available but take up was low and fewer than 20% of prisoners had used a Purple Visit (see Glossary of terms). In our survey, only 2% of prisoners said they had used a video call in the last month. We spoke to prisoners who valued this service but were frustrated that their access was limited to one 30-minute video call a month when there were plenty of free slots (see key concern and recommendation S8).

4.5 Electronic tablets had been used for one prisoner during a time of crisis and for prisoners to dial into funerals in the community. The 'email a prisoner' scheme was available, and prisoners could reply to emails they received.

4.6 There had been no face-to-face family support work since March, which was a significant gap. The family engagement worker had not attended the prison to deliver family courses and encourage prisoners to maintain family contact. Some work had been carried out remotely, for example contacting families to update them on the prison regime.

4.7 The lack of family contact since the introduction of the restricted regime had had particularly poor outcomes for some prisoners who referred to the negative impact on their well-being.

One prisoner told us: 'the majority of other prisons through this pandemic have…had a lot more chances to see family and friends. I myself have not seen my daughter in nine months now which has had a drastic effect on my mental health.'

Sentence progression and risk management

4.8 The offender management unit (OMU) consisted of prison and probation offender managers (POMs), hub managers, case administration staff and the community rehabilitation company (CRC). There had been staff shortages in the early days of the restricted regime, but the team was now well resourced. The service focused on transferring prisoners serving sentences longer than 12 months and providing support on release. Probation offender managers managed high-risk cases and prison offender managers low- and medium-risk cases, which was appropriate.

4.9 In our survey, 41% of prisoners said they knew what their custody plan objectives were and 37% of these said that staff were helping them to achieve their objectives.

4.10 Only five prisoners did not have an up-to-date assessment of their risks and needs at the time of our visit. During the last 10 months, many of these assessments had been made without speaking directly to the prisoner, which undermined the quality of offender management work. POMs relied on prisoners returning a self-report questionnaire and, if they did not consent, assessments were based on outdated information from previous assessments of risk and need. The importance of face-to-face contact to identify risks and behaviours was not recognised. In the cases that we looked at many prisoners had not had face-to-fact contact with their POM in the previous six months (see key concern and recommendation S9).

4.11 At the start of the pandemic, the prison had introduced a direct phoneline for prisoners to call into the OMU. This was available from 9am to 3pm, Monday to Friday, with a duty rota of POMs to receive calls. This service was well used. On one day 22 prisoners had called with a range of questions on topics such as home detention curfew (HDC), tracking mail and progressive moves. Prisoners told us that it was useful to be able to get a quick response to their concerns.

4.12 More than half the prisoners at Leicester were on remand or convicted, but not yet sentenced. One prisoner had been on remand for 19 months. Delays in court processes caused many prisoners to spend increasingly long periods on remand.

4.13 During the previous six months, 287 prisoners had been transferred to other establishments. In the early days of the restricted regime, transfers had been delayed which inhibited progression, but the recent introduction of offender flows had helped to move prisoners more swiftly. Most sentenced prisoners were transferred to other establishments in good time.

4.14 More than a quarter of the prisoners were sentenced. Fifteen prisoners were serving life sentences or indeterminate sentences for public protection, a reduction since our previous inspection. Some of these prisoners were temporarily based at Leicester to be closer to court, some had scheduled parole boards and others were newly sentenced and awaiting transfer. The psychology team offered one-to-one support to prisoners on indeterminate sentences but there were not enough services to support these prisoners.

4.15 Information sharing between the prison and the community was reasonable at the time of our visit, although some community services had not been easy to contact at the start of the pandemic.

4.16 Not all public protection processes were robust enough. There had not been enough staff to listen to calls resulting in a backlog. At the time of our visit, 44 prisoners were subject to telephone monitoring, but not all their calls were listened to within 72 hours. In some cases, there were delays of up to two weeks, which undermined public protection. Reviews of prisoners on monitoring were timely and decisions to continue monitoring were made by the interdepartmental risk management team.

4.17 Monthly interdepartmental risk management team meetings had continued during the restricted regime and took place in the visits hall to allow social distancing. Meetings were well attended by a range of departments and prisoners subject to public protection processes and high-risk prisoners due for release were discussed.

4.18 HDC processes were well managed, but too many eligible prisoners remained in custody after their release date. During the previous six months, 52 prisoners had been eligible for HDC, but only two-thirds of these had been approved and released on time.

Release planning

4.19 During the previous six months, 295 prisoners had been released. The Derbyshire, Leicestershire, Nottingham and Rutland community rehabilitation company (CRC) had been on site since the introduction of the restricted regime but had not provided face-to-face resettlement support to prisoners for almost 10 months. At the time of our visit, some resettlement case workers were talking to prisoners through the cell door during the lunch period about their resettlement needs. This did not afford adequate privacy.

4.20 In our survey, 54% of prisoners said they expected to be released in the next three months, 39% of whom said that someone was helping them to prepare for release. The CRC prioritised prisoners' accommodation needs before release and provided some remote finance, benefit and debt support. There were some gaps in available services and pre-release interventions and courses usually available to prisoners before release were not operating.

4.21 Reviews of prisoners' resettlement needs 12 weeks before release presented challenges in the absence of face-to-face contact. The CRC used the internal mail system to send and receive resettlement plans and the direct phone line which had been introduced helped to reinforce this (see paragraph 4.11).

4.22 Since the introduction of the restricted regime, the CRC had sourced additional support for prisoners on release, for example mobile phones with credit installed were issued to prisoners who needed them on the day of release.

4.23 During the previous six months, a new health initiative called the 'critical time intervention' (CTI) had been introduced by the mental health team (see paragraph 2.36). Outcomes of this initiative had not yet been collated.

4.24 The service provided by the homelessness prevention task force had had good outcomes for prisoners, particularly those who would have been released from prison homeless. Nineteen prisoners who had engaged with the CRC in the previous six months had been released with no fixed abode.

Section 5. Appendices

Appendix I: Scrutiny visit team

Ian Dickens	Team leader
Nadia Syed	Inspector
Rebecca Stanbury	Inspector
David Owens	Inspector
Paul Tarbuck	Health care inspector
Rahul Jalil	Researcher
Joe Simmonds	Researcher
Annie Bunce	Researcher

Appendix II: Photographs

Holding room in reception

Dirty toilet in reception

Wall unit with no doors. This meant prisoners could not secure personal items such as in-possession medication

Gazebo on the exercise yard, which allowed prisoners to take exercise even in poor weather.

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.