# Submission to the Justice Select Committee's inquiry into Prison Governance

by Her Majesty's Chief Inspector of Prisons

## Introduction

1. We welcome the opportunity to submit a response to the Justice Select Committee's inquiry into prison governance.

2. Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent inspectorate whose duties are primarily set out in section 5A of the Prison Act 1952 and include reporting on the conditions for and treatment of those in prisons and young offender institutions (YOI).

3. HMI Prisons is a member of the UK's National Preventive Mechanism (NPM), the body established to comply with the UK's obligations arising from the UN Optional Protocol to the Convention Against Torture. The NPM's focus is to prevent torture and ill-treatment in places of detention.

4. Our response is based on inspections of YOIs holding young adults and prisons. It provides information which we hope may assist the Committee in examining its terms of reference relating to monitoring of performance and the use of data and the support provided to prisons to improve outcomes.

## Support to prisons

5. A number of inspections have found that not enough is being done at regional and national levels to support establishments to improve outcomes. A lack of, or the need for, support and oversight from HMPPS was evident at all four prisons where the urgent notification process was invoked - HMP Bedford, HMP Nottingham, HMP Exeter and HMP Birmingham. Despite a Performance Improvement Plan being put in place by Her Majesty's Prison and Probation Service (HMPPS) at Bedford around two years prior to its inspection, scores had declined to poor in three of our four healthy prison assessments. My letter to the Secretary of State explained that we did not feel that HMPPS placing the prison in special measures in itself provided the assurance that the concerns raised in the inspection would be addressed. My letter in relation to Nottingham noted that the action plan drawn up to guide the implementation of inspection recommendations had obviously not been closely monitored by HMPPS senior leadership. In relation to Birmingham, I questioned how those with responsibility for the prison did not see the problems or were apparently incapable of acting when they did - an inertia seemed to have gripped those on the ground and those responsible for managing and monitoring the contracts. In the introduction to the report on Exeter, I noted that the inability to improve safety without significant intervention from HMPPS was directly relevant to my decision to invoke the urgent notification process.

6. The inspection of HMP Liverpool, which took place prior to the urgent notification process being put in place, found that requests for assistance had been met with inadequate support - "[w]hile much of what we found was clearly the responsibility of local prison managers, there had been a broader organisational failure. We saw clear evidence that local prison managers had sought help from regional and national management to improve conditions they knew to be unacceptable long before our arrival, but the resulting support was inadequate and had made little impact on outcomes for prisoners."

7. Although no urgent notification was issued in relation to HMP Lewes, its inspection called in to question the effectiveness of special measures. Despite the prison having been in special measures for two years, scores had declined in three of our four healthy prison assessments, and failed to improve in the fourth (safety). Of the 45 action points in the 'Improving Lewes (Special Measures) Action Plan', agreed with senior HMPPS management in August 2018, 39 had not been completed and the majority were noted as requiring 'major development'. There was a significant number of references to reviewing activity but a noticeable lack of clear targets.

8. The inspection of HMP High Down identified a different problem but one which also raises serious concerns about support and communication between HMPPS and governors. At the time of our inspection there were delayed plans to re-role the prison to become a category C training prison. However, no one knew whether this would definitely happen and what the plans were to enable it to happen. They told us that this was because HMPPS had not given them any more detail. The introduction to the report notes that "[t]o transform this situation in a few short months would clearly be impossible, yet the governor and team believed that they might be expected to do so." HMP Hindley had also experienced uncertainty about its future in the lead up to inspection – an announcement had been made in March 2017 that the prison would close but this was then put on indefinite hold in June 2017. The introduction to the inspection report noted that efforts to improve outcomes had been undermined by the uncertainty about the future of the prison. However, the prison had made significant improvements and the governor "had taken a pragmatic stance, working on the premise that he would not be able to rely on significant external support and the leadership and staff at Hindley would have to find solutions themselves. While this was laudable, there was clearly a limit to what they could achieve on their own. The prison had been left in a state of limbo and it was unclear whether any of the investment necessary to make the prison sufficiently safe, decent and purposeful would be forthcoming."

9. We hope to see progress at Birmingham, Bedford and High Down when we return to undertake Independent Reviews of Progress (IRPs) in the summer.[1] Reports from these reviews will be published around five weeks after each visit. In light of the concerns noted above, the provision of funding to HMI Prisons to carry out IRPs was timely and welcome.

# Use of data to drive improvements

10. Many inspections find that establishments do not collect data that would assist to improve outcomes or that those establishments collecting data are not analysing and using it effectively to identify and address issues. This is sometimes a prison-wide problem. For example, at HMP Wandsworth "there appeared to be a long-standing culture of not recording or analysing data to understand what was happening and to drive improvement. This was reflected in an obvious gap between the intentions of senior managers and what was actually happening on the wings." There was incomplete or insufficient data collection or analysis in a number of areas, including the number of assaults, outcomes of adjudications, the use of segregation and to identify protected characteristics. The community rehabilitation company could not provide validated data to evidence progression to employment, training or education on release.

11. In other prisons, collection and analysis of data is inconsistent with good collection and use in some areas but not in others. For example, at HMP Lindholme, inspectors noted that the safer custody team had comprehensive methods to record data and there was also good analysis of complaints data. However, there was no formal group to analyse and monitor the range of

[1] IRPs are announced two to three months prior to taking place and the IRP schedule will be updated accordingly. Further information about these reviews and the announced schedule can be located at https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/independent-reviews-of-progress-irps/ and in the letter provided to the Justice Committee, https://www.parliament.uk/documents/commons-committees/Justice/correspondence/080419-Peter-Clarke-HMCIP-new-processes.pdf.

data collected about segregation, and the prison was not receiving sufficient data to analyse outcomes for prisoners in relation to education, training and employment on release.

12. Inadequacies in data collection and use are found across all four of HMI Prisons' healthy prison areas (safety, respect, purposeful activity and rehabilitation and release planning). Examples in relation to each of these areas are set out below.

13. At HMYOI Ayslebury, inspectors found that data which would assist to improve safety outcomes were not always collected or utilised. For example, the proposed violence reduction strategy was not based on data such as information from previous incidents and the analysis of data relating to self-harm was limited – although some information on individual incidents was presented at the safer custody meeting, there was little evidence that this was used to identify trends and patterns that would help to inform a reduction plan. At HMP Lewes, inspectors noted that "[a]lthough data on self- harm were presented to the meeting, there was little documented discussion or actions resulting. The HMPPS safety diagnostic tool was not used to reduce the high number of incidents."

14. In the assessment of respect, we often identify inadequate collection and use of data in equality and diversity work. For example, the inspection of HMP Liverpool found that the equality monitoring tool data was incomplete, with the most recent report not providing information on disability, nationality or sexuality. At HMYOI Aylesbury, although a quarterly meeting considered some useful equality-related data, including from local monitoring additional to the national monitoring tool, this did not lead to clearly identifiable actions and not enough was done to understand why there were inequitable outcomes for prisoners. We reported that "[e]vidence of potential discrimination from equality monitoring data was not addressed robustly."

15. In relation to purposeful activity, at HMP Bedford, inspectors noted that data collection and analysis of library usage was developing but data were not yet being used effectively to increase attendance. In addition, accurate and meaningful data on prisoner's involvement in education, training and employment on release was not being gathered. At HMP Birmingham, inspectors recommended that data be collected in relation to library attendance and gym use in order to ensure equitable access and improve participation.

16. At HMP Liverpool, inspectors reported that although Shelter was providing assistance to prisoners with accommodation needs, accurate data to establish how many prisoners found sustainable accommodation on release were not collected. Inspectors therefore recommended that "[o]utcome data on sustainable housing should be collected and analysed to ensure that provision for prisoners is appropriate and effective." At HMP The Mount, a resettlement needs analysis had been undertaken, however, this was based exclusively on prisoner questionnaires and did not include offender assessment system (OASys) data. The analysis had not been used to inform the strategic direction of the prison.

# Conclusion

17. As highlighted above, a number of inspections have seriously called in to question the support provided at a national and regional level to establishments that are clearly struggling to provide safe and decent care for those detained within them. It is difficult to understand how problems were either not identified or addressed to prevent these establishments declining, some of them to point of being unsafe and uninhabitable. In addition, establishments should not suffer from uncertainty about their future role. At a local level, inspections far too often find that even simple data collection is not being undertaken or when undertaken, is not effectively utilised to drive improvements.

18. I hope that you find this information useful and should you require anything further, please do not hesitate to contact me.

**Peter Clarke CVO OBE QPM** **May 2019**
HM Chief Inspector of Prisons