



Report on an unannounced  
inspection of

## **HMP Belmarsh**

by HM Chief Inspector of Prisons

26–27 July and 2–6 August 2021



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## Introduction

Belmarsh is a high-security, men's prison in south-east London that held 675 men at the time of our inspection, of whom nearly 60% were unsentenced and 17% were category A prisoners. Within the jail there is also high secure unit. The prison services the London courts, particularly Woolwich and the Old Bailey, but because of reduced courtroom space created by COVID-19 restrictions, prisoners had been attending courts further afield. This had led to a strain on resources in the prison because more staff were required for escort duty.

While maintaining a strong security focus, the governor had set out to improve relationships between officers and prisoners and to create a more representative and caring staff team. Although this change was not manifested in our survey results, inspectors commented on the many positive interactions they saw in the jail and prisoners often told us about supportive staff members. Leaders recognised there was further work to be done to improve the culture in the prison: for example, many staff routinely failed to collect or turn on body-worn cameras and we saw officers who were supposed to be supervising the most vulnerable prisoners, sitting reading the paper.

Although the prison felt generally well-ordered and calm, levels of violence had risen since our last inspection despite COVID-19 restrictions limiting the time most prisoners were out of their cells. While the prison collected data on violence and use of force, it was not being used to support the development of an effective strategy for reducing violence. It was concerning that there had been no violence reduction meeting for more than a year.

The underuse of data was something of a theme of this inspection – leaders did not have an adequate plan to consider outcomes for different groups such as the disproportionate use of force on black and younger prisoners, and neither data nor consultation were used to understand and address these or other disparities. While the prison's self-assessment report (SAR) suggested violence had reduced because there were fewer incidents, in reality, with fewer prisoners in the jail, rates were actually increasing.

The prison had not paid sufficient attention to the growing levels of self-harm and there was not enough oversight or care taken of prisoners at risk of suicide. Urgent action needed to be taken in this area to make sure that these prisoners were kept safe.

The 52% of prisoners who were not working were spending 23 hours a day locked in their cells while the education block, gym and library had sat empty and unused for more than a year. The provider was finally running some face-to-face education on the wing, though access was limited, and some prisoners were getting taught through their cell doors during the lunchtime lockdown. In-cell work packs were being offered to prisoners, but engagement had been low and prisoners in the high secure unit received no regular education. Two men who had volunteered to be reading mentors had received no training, materials or support.

The governor had a strong vision for the future of the prison, but for this to be realised she will need to strengthen her senior team and make sure that there is more rigorous oversight of some of the key areas – such as care for the most vulnerable prisoners, effective safety strategies and a better understanding of disparities between different groups – and use data to understand the challenges, set targets and measure progress.

**Charlie Taylor**

HM Chief Inspector of Prisons

September 2021

# About HMP Belmarsh

## Task of the prison

A local prison holding adult and young adult men, some of whom require a high level of security.

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

Prisoners held at the time of inspection: 675

Baseline certified normal capacity: 792

In-use certified normal capacity: 792

Operational capacity: 773

## Population of the prison

- 1,481 new prisoners received each year (around 124 per month).
- 150 foreign national prisoners.
- 57% of prisoners from black and minority ethnic backgrounds.
- Unsentenced prisoners make up almost 60% of the population.
- 212 prisoners receiving support for substance misuse.
- Up to 240 prisoners a month referred for mental health assessment.

## Prison status (public or private) and key providers

Public

Physical health provider: Oxleas NHS Foundation Trust

Mental health provider: Oxleas NHS Foundation Trust

Substance misuse treatment provider: Change Grow Live (CGL)

Prison education framework provider: Milton Keynes College

Escort contractor: Serco

## Prison department

Long term and high security estate

## Brief history

Belmarsh is in Thamesmead, South East London and was opened in 1991. It is one of 12 long term and high security prisons, but the only core local prison in the high security estate. It also operates a high secure unit (HSU) for prisoners presenting the very highest risk of escape.

## Short description of residential units

House block 1 – 174 older prisoners, life sentence and mixed population.

House block 2 – 174 on short sentences, remands and mixed population.

House block 3 – 174 on first night centre/induction and remand prisoners.

House block 4 – 171 on vulnerable prisoners spur and mixed population.

High secure unit (HSU) – a self-contained unit holding up to 47 prisoners who require a high level of security (including a small discrete segregation unit for HSU prisoners only).

Segregation unit – holding up to 16 prisoners serving periods of punishment or needing to be separated from others. It also contains two designated prison rule

46 cells used for the temporary management of close supervision centre (CSC) system.

Health care inpatients – a 33-bed inpatient facility staffed jointly by Oxleas NHS Foundation Trust and HMPPS.

**Name of governor and date in post**

Jenny Louis, February 2021 (acting governor since July 2020).

**Leadership changes since the last inspection**

Rob Davis, governor from 2016 until July 2020.

**Prison Group Director**

Will Styles from May 2019.

**Independent Monitoring Board chair**

Fiona Neale

**Date of last inspection**

January–February 2018

## Section 1 Summary of key findings

- 1.1 We last inspected Belmarsh in 2018 and made 40 recommendations, six of which were about areas of key concern. The prison fully accepted 31 of the recommendations and partially (or subject to resources) accepted six. It rejected three recommendations.
- 1.2 Section 8 contains a full list of recommendations made at the last full inspection and the progress against them.

### Progress on key concerns and recommendations from the full inspection

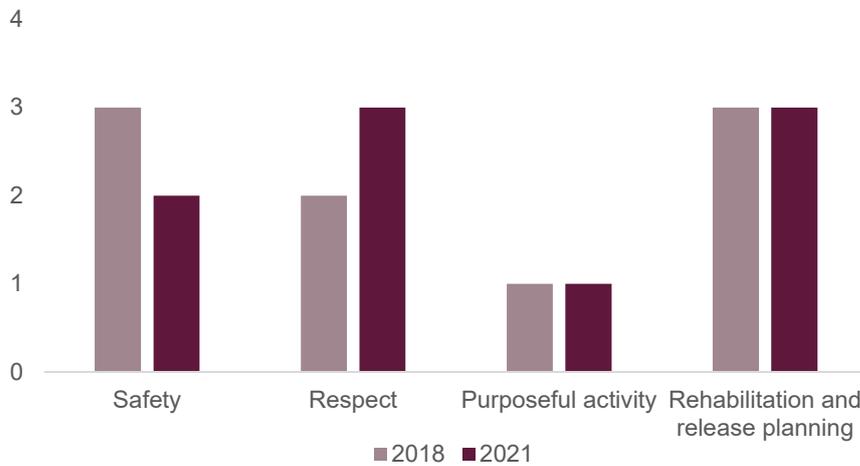
- 1.3 Our last inspection of Belmarsh took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for prisoners at the time. Although we recognise that the challenges of keeping prisoners safe during COVID-19 will have changed the focus for many prison leaders, we believe that it is important to report on progress in areas of key concern to help leaders to continue to drive improvement.
- 1.4 At our last full inspection, we made one recommendations about a key concern in the area of safety. At this inspection we found that this recommendation had not been achieved.
- 1.5 We made three recommendations about key concerns in the area of respect. At this inspection we found that one of those recommendations had been achieved, one had been partially achieved and one had not been achieved.
- 1.6 We made two recommendations about key concerns in the area of purposeful activity. At this inspection we found that one of those recommendations had been partially achieved. Ofsted carried out a progress monitoring visit alongside our inspection to assess the progress that leaders and managers had made towards reinstating a full education, skills and work curriculum. They judged it was too early to assess whether recommendations made at the last inspection had been achieved.

### Outcomes for prisoners

- 1.7 We assess outcomes for prisoners against four healthy prison tests (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).
- 1.8 At this inspection of Belmarsh, we found that outcomes for prisoners had stayed the same in two healthy prison areas, improved in one and declined in one.
- 1.9 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account

the prison's recovery from COVID-19 as well as the 'regime stage' at which the prison was operating, as outlined in the HM Prison and Probation (HMPPS) National Framework for prison regimes and services.

**Figure 1: HMP Belmarsh healthy prison outcomes 2018 and 2021**



## Safety

At the last inspection of Belmarsh in 2018 we found that outcomes for prisoners were reasonably good against this healthy prison test.

At this inspection we found that outcomes for prisoners are now not sufficiently good.

- 1.10 Reception was clean and functional, and the first night centre was a comfortable environment that provided some good support. New arrivals could not routinely discuss any immediate anxieties in private with an officer or a Listener (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) on their first night, but officers did conduct overnight safety checks. The induction programme was delivered in person to every prisoner. However, the content was delivered in English, including to those who did not understand English. Although prisoners were provided with a useful induction booklet translated into commonly used languages, this did not give them the opportunity to interact or ask questions at a crucial point in their prison journey. Delivery of the induction programme required greater staff oversight and the regime on the unit was limited.
- 1.11 In our survey, one in four prisoners said they felt unsafe. Incidents of violence had increased since our last inspection. Challenge, support and intervention plans (CSIPs, see Glossary of terms) were used appropriately to manage the most serious perpetrators of violence, but support for victims was underdeveloped. The violence reduction strategy did not address the specific issues relevant to Belmarsh. A weekly safety intervention meeting was well attended and discussed prisoners of concern. The strategic meeting to discuss wider issues of

violence had stopped in early 2020 and it was not clear how leaders were driving the action plan to make the prison safer.

- 1.12 The use of force had increased since our last inspection. Staff did not routinely activate body-worn video cameras during incidents. Due to the lack of video footage to support staff statements, we could not be assured that the use of force was necessary in all cases. A comprehensive monthly report contained a useful range of data, but there had been no use of force governance meetings to provide adequate scrutiny and assurance.
- 1.13 The segregation unit was clean and well staffed. Prisoners were offered a daily regime, although those who refused to relocate back to the main prison were still deprived of a daily shower, which was unjustifiable. Prisoners and staff on the unit benefited from support from a forensic psychologist and there had been efforts to reintegrate a few very complex prisoners. However, overall, governance of segregation was relatively weak.
- 1.14 The security team identified appropriate security objectives. The introduction of dedicated staff to oversee prisoners affiliated to gangs was a positive initiative. There was a robust approach to the monitoring of extremism and corruption prevention. Drug testing had recently resumed and the use of suspicion testing was effective. Leaders were sighted on the risks of illicit items coming into the prison and made effective use of technology to reduce supply.
- 1.15 There had been four self-inflicted deaths since the last inspection. There was a good action plan to embed Prisons and Probation Ombudsman recommendations from investigations into the deaths, but the quality of suicide attempt investigations was very poor. Recorded levels of self-harm were lower than at most similar prisons, but were nearly four times higher than at the last inspection. The written strategy and action plan were not used effectively to reduce self-harm. Prisoners most at risk had been identified for welfare checks, but there was only a limited range of wider support. The quality of support delivered through assessment, care in custody and teamwork (ACCT) case management was weak. We were not assured that prisoners subject to constant supervision were always kept safe. The prison did not check the safer custody hotline frequently enough. There were no adult safeguarding processes in place.

## Respect

At the last inspection of Belmarsh in 2018 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

At this inspection we found that outcomes for prisoners were now reasonably good.

- 1.16 Staff-prisoner relationships had improved since our last inspection and many staff treated prisoners with respect. Most had a reasonable

knowledge of the prisoners under their care and we observed good interactions. The absence of key work affected the development of more productive relationships.

- 1.17 Communal areas and facilities were generally clean and outside areas were well maintained. Double cells were no longer used to accommodate three prisoners. Cells were furnished and equipped with basic items, but some needed redecoration. Some showers were in a very poor condition, although work was under way to replace them. The high secure unit (HSU) was uncomfortably hot during hot weather and portable air conditioning units only partially addressed this. Most exercise areas were reasonable and equipped with fixed exercise machines, but the yard on the HSU had none and was comparatively austere.
- 1.18 The food was of reasonable quality and quantity, but meals were served too early. Prisoners had very limited opportunities to prepare their own food. There were weaknesses in the systems to provide prisoners with property and catalogue orders.
- 1.19 General consultation arrangements were good and had led to positive changes. Complaints were properly tracked to monitor completion and were quality assured, but there were major weaknesses in the applications process. Prisoners had good access to legal visits and there had been a significant increase in the use of video-link for judicial proceedings.
- 1.20 Equality work was undermined by an out-of-date strategy and lack of a multidiscipline meeting to develop and drive action planning. This was further compounded by limited consultation with prisoners with protected characteristics and poor use of data. Support for foreign national prisoners was poor and telephone interpreting services were not well used. Equality peer representatives had been identified but they lacked training and purpose. The chaplaincy had continued to provide good support to prisoners throughout the pandemic, although the return to corporate worship had taken time.
- 1.21 Health services had improved and were very good. They were well led and partnership working with the prison was strong. Clinical governance was robust, including improved management of complaints, and assertive oversight of care delivery in prisoners' early days. Primary care services remained comprehensive and most had continued during the regime restrictions. The non-attendance rates for appointments were low and waiting lists relatively short. As at the last inspection, too many prisoners resided in the inpatient unit for non-clinical reasons, which led to the disruption of a therapeutic regime. Mental health services were responsive, but there were unacceptable delays in transferring prisoners to hospitals under the Mental Health Act. Social care was exemplary and substance misuse services provided a good range of interventions. Pharmacy services and medicines management were good, and dental services were very good.

## Purposeful activity

At the last inspection of Belmarsh in 2018 we found that outcomes for prisoners were poor against this healthy prison test.

At this inspection we found that outcomes for prisoners remained poor.

- 1.22 Ofsted carried out a progress monitoring visit of the prison alongside our full inspection and the purposeful activity judgement incorporates their assessment of progress. Ofsted's full findings and the recommendations arising from their visit are set out in Section 5.
- 1.23 The majority of prisoners spent up to 23 hours a day locked in their cells and some did not receive a full hour of outdoor exercise or daily shower. The regime on the HSU was often reduced further due to staff shortages.
- 1.24 The library had been closed since the beginning of the pandemic, and there was no timescale for reopening it, but a remote lending service was operating. The gym had also closed and had still not reopened. Most prisoners could only access weekly outdoor PE.
- 1.25 Education, skills and work had been available to only a small number of prisoners during the restricted regime. Leaders and managers had provided some in-cell work, but too few prisoners were participating in education in this way. HSU prisoners had no routine access to education.
- 1.26 New arrivals received an in-cell education induction pack that included an initial assessment of their English and mathematics skills and the identification of any learning difficulties or disabilities. Prisoners with entry-level literacy skills or whose first language was not English struggled with these packs and too many were not completed. As a result, staff did not have sufficient information to allocate prisoners to the most appropriate purposeful activity.
- 1.27 Prisoners had very recently started to benefit from one-to-one, face-to-face education support. However, they could not phone education staff and had to rely on making requests for help in writing, which limited support. A few prisoners had recently been able to sit examinations leading to qualifications, but, overall, the proportion of accredited qualifications available to prisoners was too low.
- 1.28 Leaders had identified the education and skills programmes they planned to implement, but could not provide sufficient detail of how they would return to classroom-based teaching.
- 1.29 Staff from education, the prison and the newly appointed information, advice and guidance service worked in partnership to prioritise prisoners in most need of support. This service was still in its infancy, but was starting to benefit the small number of prisoners who had accessed it.

- 1.30 Training in commercial workshops was appropriately planned and delivered. Prisoners identified as having a learning difficulty or disability had started to receive face-to-face support on an individual basis.

### Rehabilitation and release planning

At the last inspection of Belmarsh in 2018 we found that outcomes for prisoners were reasonably good against this healthy prison test.

At this inspection we found that outcomes for prisoners remained reasonably good.

- 1.31 Visits had recommenced in May 2021 and now allowed limited physical contact. Secure video calling had been well promoted and take-up was excellent. In-cell telephones enabled prisoners to call home regularly.
- 1.32 Reducing reoffending work was not based on a recent needs analysis and the monthly meeting was not sufficiently strategic or action-focused. Prison offender managers (POMs) had more manageable caseloads than at the previous inspection. This should have enabled greater in-depth support, but the recorded contact with prisoners was infrequent. The prison did not transfer prisoners out until their initial OASys (offender assessment system) assessment report had been completed, which was positive. Recategorisation decisions were prompt and prisoners were generally moved to the most appropriate establishments quickly.
- 1.33 There was effective oversight of prisoners subject to multi-agency public protection arrangements (MAPPAs). Risk management for the release of high-risk prisoners was generally good and subject to regular scrutiny and guidance from the senior probation officer. However, there was no oversight of phone monitoring arrangements and too many calls had not been listened to.
- 1.34 The prison delivered two accredited programmes, which were appropriate to the population, and waiting lists were small. The psychology team had developed meaningful one-to-one interventions for prisoners who were unsuitable for programmes.
- 1.35 Recent national changes meant that resettlement work (previously the responsibility of the community rehabilitation company) no longer included support for the 60% of unsentenced prisoners at Belmarsh, which was a significant loss of provision. The job coach was still working remotely and there had been little careers provision, so many prisoners did not have a development plan for education, training or employment on release. In the previous 12 months, 18% of sentenced prisoners had been released without settled accommodation, which was a significant concern.

## Key concerns and recommendations

- 1.36 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.
- 1.37 During this inspection we identified some areas of key concern and have made a small number of recommendations for the prison to address those concerns.
- 1.38 Key concern: Levels of violence had continued to increase since the last inspection and too many prisoners felt unsafe. Despite available prison data, leaders did not analyse the indicators of violence in detail. The prison's strategy and associated action plan did not reflect the risks it faced and there had been no formal strategic meeting to address violence for over 18 months.

**Recommendation: Safety data should be used to inform a strategy and action plan to reduce increasing levels of violence, which leaders monitor and drive effectively.**

(To the governor)

- 1.39 Key concern: Governance of use of force had lapsed. Most incidents were spontaneous, but staff did not routinely activate body-worn video cameras. Despite good local data, there was no effective analysis or detailed scrutiny of force to make sure that incidents were necessary, justified and proportionate.

**Recommendation: There should be robust scrutiny of the use of force, including data, camera footage and staff statements, to make sure that force is necessary, justified and proportionate.**

(To the governor)

- 1.40 Key concern: The quality of case management support for prisoners at risk of suicide and self-harm was weak: risk was not always assessed correctly; some case reviews were too infrequent; and care plans were missing or poorly completed. Records of prisoners' interactions were often missing. It was clear that staff had struggled to implement the new version of ACCT.

**Recommendation: Prisoners at risk of suicide and self-harm should receive additional support through the use of good quality assessment, care in custody and teamwork (ACCT) case management that includes an accurate assessment of their risk, sufficiently frequent case reviews, appropriate support actions recorded in a care plan and a consistent record of their daily interactions.**

(To the governor)

- 1.41 Key concern: Constant supervision arrangements for prisoners at the highest risk of suicide and self-harm were unsafe. Staff read newspapers rather than observing the prisoners, who were also sometimes left unsupervised and unobserved. Supervising staff worked long shifts, which affected their concentration, and they did little to encourage prisoner interaction and participation in anything purposeful.

**Recommendation: Constant supervision arrangements should keep prisoners at risk safe and encourage them to engage with a purposeful regime wherever possible.**

(To the governor)

- 1.42 Key concern: There were substantial weaknesses in equality work. The equality strategy was out of date and there was no multidisciplinary meeting to develop and drive action planning. There was limited consultation of prisoners in protected groups and little consideration of equality monitoring data.

**Recommendation: Equality data and effective consultation should inform an effective strategy and action plan that leaders drive proactively to address disproportionate outcomes for prisoners from protected groups.**

(To the governor)

- 1.43 Concern: Prisoners who were not working spent up to 23 hours a day locked in their cells. Only 23% prisoners were engaged in out-of-cell purposeful activity. Most prisoners had around 45-50 minutes outdoor exercise each day, although some got as little as 30 minutes. Association had not been available in the main prison since the restricted regime commenced in March 2020. The library remained closed and there were no developed plans to reopen it. Unlike in other prisons, the gym was still closed.

**Recommendation: The core day should provide adequate time out of cell for purposeful activity, domestic tasks and recreation to assist with the rehabilitation of prisoners and to improve their well-being.**

(To the governor)

- 1.44 Key concern: The decision to stop resettlement workers providing advice and support to unsentenced prisoners was a significant loss to these prisoners, who made up almost 60% of the population. While the decision was outside the control of the prison, it had not put in place any measures to mitigate this.

**Recommendation: All prisoners, including those who are unsentenced, should be able to access resettlement advice and support to prepare them for their release into the community.**

(To HMPPS)

## **Notable positive practice**

- 1.45 We define notable positive practice as innovative work 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.
- 1.46 Inspectors found five examples of notable positive practice during this inspection.
- 1.47 A useful induction booklet had been translated into commonly spoken languages. (See paragraph 3.7.)
- 1.48 The monthly use of force data pack contained a range of information that could be used to identify good practice and areas of concern so that immediate action could be taken, practice improved and learning shared. (See paragraph 3.30.)
- 1.49 The weekly security intelligence assessment and associated report enabled the prison to respond appropriately to emerging security and safety concerns. (See paragraph 3.41.)
- 1.50 Consistent monitoring of actions arising from health screening and assessment of new patients meant they were supported at a vulnerable point in their prison lives. (See paragraph 4.61.)
- 1.51 Belmarsh placed a transfer hold on prisoners who required completion of an OASys assessment to make sure that this process was not passed on to other establishments. (See paragraph 6.10.)

## Section 2 Leadership

**Leaders provide the direction, encouragement and resources to enable good outcomes for prisoners.** (For definition of leaders, see Glossary of terms.)

- 2.1 Good leadership helps to drive improvement and should result in better outcomes for prisoners. This narrative is based on our assessment of the quality of leadership with evidence drawn from sources including the self-assessment report, discussions with stakeholders, and observations made during the inspection. It does not result in a score.
- 2.2 The prison worked closely with health providers and Public Health England to respond to the COVID-19 pandemic in the prison, successfully managing three outbreaks. One prisoner had died who was COVID-19 positive. Despite concerted effort by leaders and partners, a significant number of prisoners refused to have the vaccine.
- 2.3 The governor and most of the senior team were passionate about shifting the culture to one focused on care and compassion. There was a generally positive atmosphere in many areas of the prison, and we encountered some enthusiastic and capable staff who were contributing to this improving culture. Some leaders welcomed the scrutiny of inspection and took immediate remedial action to address concerns raised during our inspection.
- 2.4 Good leadership and partnership working in areas including health, security and the offender manager unit were a strength. However, some functional heads did not have an accurate picture of important issues in their area. They did not use data well to assess their current position, identify risks, set priorities and inform action plans. Important strategic meetings designed to share information and drive improvement were still in abeyance or had only reconvened some 16 months after restrictions had begun. Quality assurance processes and oversight from leaders had not been sufficiently robust to pick up these issues.
- 2.5 The prison was well resourced to reflect the complexity of the population it managed. However, the allocation of resources provided some departments with a strong staffing profile at the expense of others that were not always adequately staffed.
- 2.6 Some of the weaknesses in delivering good outcomes were out of the control of local leaders. For example, the reconfiguration of courts across London had made a significant impact on staff resources (see paragraph 3.1). Also, many prisoners would now be released from local prisons like Belmarsh with little resettlement support because the arrangements replacing the community rehabilitation company (CRC, see Glossary) contract only provided a service for sentenced prisoners.

2.7 Leaders and staff were unable to articulate what future regimes would look like in any detail. Belmarsh was supposed to be operating at level 3 of the HMPPS recovery framework (see Glossary), but some of the activity permitted at this level was only at an early planning stage. There was still no classroom education and the library remained closed with no firm plans to reopen. Additionally, prisoners could still not access any indoor gym or PE provision. Despite there being many months during lockdown to refurbish washroom facilities in the gym, this work continued into stage 3 and prohibited access at a time when prisoners had little else to occupy their time.

## Section 3 Safety

**Prisoners, particularly the most vulnerable, are held safely.**

### Early days in custody

Expected outcomes: Prisoners transferring to and from the prison are safe and treated decently. On arrival prisoners are safe and treated with respect. Risks are identified and addressed at reception. Prisoners are supported on their first night. Induction is comprehensive.

- 3.1 Reception was usually busy, with about 30 new admissions a week and a large number prisoners leaving for court appearances. There were many category A prisoners attending court who needed a prison officer escort. The London courts had been reconfigured to address the backlog of cases that had built up during the pandemic. This meant court cases were further away and requirements for escorting sometimes took a large number of staff away from the daily running of the prison. The proportion of court appearances using video link had almost doubled since the last inspection to about 30% (see paragraph 4.29), but the facility was still very underused and typically less than half of the available sessions were taken up.
- 3.2 Reception was clean and functional. All prisoners were handcuffed between the escort van and reception and were strip searched as well as placed in the body scanner.
- 3.3 There was too little advice and guidance for arrivals in reception. Prisoner orderlies only carried out functional tasks and there was no information in holding rooms explaining what new arrivals could expect in their first few days.
- 3.4 Although staff aimed to move new arrivals to the first night centre quickly, there were sometimes delays while prisoners returning from court were received and taken back to their cells. Although some of these prisoners faced extended trials and potentially long sentences, they could not see a Listener (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) in reception before they were taken back to their cells.
- 3.5 New arrivals were taken to the first night centre on house block 3. This was a comfortable and spacious environment, with some good support from orderlies while prisoners waited to complete first night processes. They were given a hot meal, but only after they had completed interviews with the health care and prison staff, which meant a wait of up to two and a half hours; this was too long and unnecessary. In our survey, only 16% of prisoners said they had been able to shower on their first night. Prisoners arrived on vans well into the evening, when there were fewer staff available to facilitate access to the showers.

- 3.6 In our survey, only 27% of prisoners said that they could speak to a Listener on their first night. Although some orderlies on the first night centre were Listeners, this was not their core duty and they did not offer a listening service to new arrivals. Instead they provided a functional role issuing paperwork and making tea. There was no routine opportunity for new arrivals to discuss any immediate anxieties with an officer in private on their first night. As at the last inspection, interviews took place in a room with other prisoners present, which did not support the disclosure of sensitive information. Apart from a question on the risk of suicide and self-harm, staff did not speak to prisoners enough about how they might be feeling on their first night.
- 3.7 There was inadequate first night or induction support for prisoners who could not speak English. We saw staff persist with a first night interview even when it became obvious that the prisoner did not understand them. Instead of using professional telephone interpreting services, they eventually asked another new arrival to interpret sensitive information, which was inappropriate. The induction programme was delivered in English, including to the prisoners who could not understand what was being said. Although prisoners were provided with a useful induction booklet translated into commonly used languages, this did not give them the opportunity to interact or ask questions at a crucial point in their prison journey.
- 3.8 First night cells were clean, but stark and unwelcoming. Items such as a kettle and television had sometimes been thrown on the mattress. There were no curtains and no information on display. Officers conducted overnight safety checks on new arrivals.
- 3.9 Induction was reliably delivered the following morning in person to every prisoner. This consisted of a slide show presented by a peer worker. There was too much detail for those new to custody to absorb and it was delivered much too quickly to be useful. There was no staff oversight of what the peer worker was telling prisoners. The introduction of useful information on a prison TV channel was promising, but so far only consisted of text.
- 3.10 Prisoners spent an average of 10 days quarantining on house block 3. The unit was used to accommodate a mixture of new quarantining prisoners, longer term prisoners, vulnerable prisoners and those in conflict; these different groups had to be kept separate. This required staff to deliver up to 10 different regimes throughout the week. Consequently, new arrivals only received about 45 minutes a day out of cell. Arrangements for infection control on house block 3 were weak, as prisoners who arrived from court the day before were potentially mixing with prisoners about to complete their quarantine.
- 3.11 Newly arrived vulnerable prisoners spent at least one night on house block 3 to access first night services and detoxification treatment, and had to be unlocked separately. They later moved on to house block 4 to finish their quarantine.

## Recommendations

- 3.12 **All new arrivals should have a private interview with a member of prison staff on their first night.**
- 3.13 **Listeners should be able to carry out their role throughout the reception, first night and induction processes.**
- 3.14 **Induction from peer workers should be overseen by a member of staff.**

## Managing behaviour

Expected outcomes: Prisoners live in a safe, well ordered and motivational environment where their positive behaviour is promoted and rewarded. Unacceptable conduct is dealt with in an objective, fair, proportionate and consistent manner.

### Encouraging positive behaviour

- 3.15 As in our inspection in 2018, incidents of violence had continued to increase, but remained broadly comparable with other local prisons with less complex populations. Much of the violence involved external gang issues and younger prisoners.
- 3.16 In the previous 12 months, there had been 341 recorded violent incidents, compared with 274 in the same period before our last inspection. Prisoner-on-prisoner violence accounted for much of the increase, while assaults against staff were similar to 2018. The number of serious incidents had, however, reduced by 14%.
- 3.17 In our survey, 60% of prisoners said that they had felt unsafe at some point at Belmarsh and one in four felt unsafe at the time of our visit. Only 50% of respondents said that they had not experienced any victimisation by staff, and significantly more prisoners than in similar prisons said they had experienced some verbal or physical abuse from staff. The increasing levels of violence, combined with our survey data, did not support the view among some staff that prisoners were safer under the restricted regime.
- 3.18 The safer custody team had benefited from increased staffing, but there was only one designated violence reduction officer. Challenge, support and intervention plans (CSIPs, see Glossary) were raised for prisoners who posed a risk to others or required more specific support and the plans were tracked by the designated officer. A dedicated spur on house block 4 continued to be used for vulnerable prisoners, but support for victims of violence was underdeveloped, with limited follow-up or formal interventions.
- 3.19 The prison's written violence reduction strategy did not address the issues specific to Belmarsh and was not effective in addressing violence at all levels. The violence reduction officer produced a monthly

data report highlighting that the most significant risk groups were younger prisoners and those with gang affiliations. This was supported by use of force statistics and data collated by the security team. Despite this, work to address these areas of risk did not yet feature in the published strategy.

- 3.20 A well-attended, weekly safety interventions meeting discussed current cases of self-harm and violence and enabled managers to follow up immediate concerns and actions. This meeting was operationally focussed and did not track delivery of the prisons overall strategy to reduce violence. Indeed, there had been no forum to drive delivery of the strategy since early 2020. The violence reduction action plan was also very limited and, in the absence of any strategic safety meetings, it was not clear how the plan was monitored or reviewed. (See key concern and recommendation 1.38.)
- 3.21 Funding had recently been secured for additional security staff to monitor gang activity and manage complex 'keep-apart' systems (see paragraph 3.40). However, this work was not embedded in the safety team and there was no current vision of joint working to address gang violence.
- 3.22 In line with national policy, very few prisoners had been placed on to the basic level of the prison's incentives scheme in the previous 12 months. The cases that we examined had defensible decision logs, which had been suitably reviewed. The local incentives scheme was based on standard HMPPS policy and there had been limited creativity on methods to motivate and encourage prisoners.

### **Adjudications**

- 3.23 There had been an average of 120 adjudications a month in the previous year, which was similar to other local prisons. During 2021, and despite the restricted regime which meant prisoners were unlocked for less time, there had been a notable increase in the number of charges laid. Only a small number of cases were outstanding at the time of our visit.
- 3.24 The written records of hearings that we examined indicated that proceedings were conducted fairly and that prisoners were given the opportunity to explain their version of events.
- 3.25 Adjudication data were presented to a segregation, management and review group meeting. However, the regularity and records of these meetings were poor. There was no evidence of detailed data analysis to identify trends or emerging themes to inform local tariffs and deter poor behaviour.

### **Use of force**

- 3.26 The recorded use of force had doubled since our last inspection, even though there had been a reduction in the population and prisoners were locked up for longer. There were with 503 recorded incidents in

the previous 12 months compared with 230 in the same period before our previous visit. Managers concluded that the increase was due to improved recording procedures; however, we found some notable frailties in the governance of use of force (see paragraph 3.30), which may also have affected the increase. The rates of recorded force were broadly similar to other local prisons.

- 3.27 In our survey, 41% of prisoners aged 25 or under said that they had been physically restrained at Belmarsh compared to 11% of over 25-year-olds. Data confirmed that a disproportionate number of incidents involved the youngest prisoners. Force was also used on a disproportionate number of prisoners from a black or minority ethnic background. This was reflected in our survey, in which 41% of prisoners under 25 said that they had been physically restrained in the last six months compared with 11% of over-25s.
- 3.28 Staff did not routinely activate body-worn video cameras during incidents of force and our checks showed that around a third of cameras had not been collected by staff when they came on duty. In 11 uses of force that we reviewed, only three had video footage available. This was an ongoing concern; for example, for the months of January and June 2021, a total of 84 incidents of force were recorded, of which 80 were spontaneous, yet less than 30% had evidence that body-worn cameras had been activated. Even where footage was recorded, in many cases it had not been correctly retained and was no longer available to view. (See key concern and recommendation 1.39.)
- 3.29 The use of force coordinator had materially reduced the backlog of written reports since 2018. The prison had also introduced the new HMPPS electronic system to record use of force documentation and nearly all reports that we examined were detailed and well written. Nevertheless, due to the lack of video footage to support staff statements, we could not be assured that the use of force was necessary in all cases. (See key concern and recommendation 1.39.)
- 3.30 The coordinator also produced a comprehensive monthly data report, which contained useful data on ethnicity, reasons for force, hotspots and staff using restraint. Reports provided clear evidence that force was more likely to be used against younger prisoners and those from a black or minority ethnic background. Despite the availability of this valuable data, general governance of the use of force was weak. Use of force meetings had lapsed until shortly before the inspection and there had been no systematic review of incidents of concern. Leaders were not able to provide evidence of adequate scrutiny and assurance. (See key concern and recommendation 1.39.)

## **Segregation**

- 3.31 Although the segregation unit was only half full when we visited, the number of prisoners segregated was increasing with 159 segregated in the first six months of 2021. Most of the prisoners held there had complex and challenging behaviour, and were risk-assessed to be unlocked with several officers present. There was an inappropriate

overlap between the use of segregation and the inpatient unit (see paragraph 4.69). At the time of our inspection, a prisoner with mental health issues who needed constant supervision was being held in the segregation unit because the appropriate cells in health care were full.

- 3.32 The segregation unit had 16 cells and was clean, well maintained and well staffed. The yard was large and partially covered, but there was nowhere to sit. Prisoners could make a phone call in private while out on the yard.
- 3.33 Prisoners in the unit were never allowed to exercise or associate together, so while it was possible to deliver a full hour of exercise when we visited, each prisoner's daily time out of cell was much reduced when the unit was full. In our survey, less than a quarter of prisoners who had been recently segregated said they make a phone call or exercise every day, and only 12% said they could shower daily, which was inadequate given the staff complement. Records showed that prisoners were offered a regime once every day at about 8am, but only if they were ready and dressed, which was not always a realistic expectation among this population. There was no further attempt to persuade prisoners to come out of their cells during the day.
- 3.34 The unit could hold two prisoners from a national close supervision centre (see Glossary) population and was doing so during our inspection. These prisoners were located there for various reasons, such as to accommodate accumulated visits from family members living locally. These prisoners received the same regime as other prisoners on the unit.
- 3.35 There had been some good work to reintegrate a few very complex prisoners into the general population, which included outreach visits from segregation staff to these individuals on residential units to support their progress. However, prisoners who refused to relocate to the house blocks were still deprived of showers on alternate days and were subject to a 'refusal regime', which was wholly unjustifiable.
- 3.36 Prisoners and staff benefited from support from a forensic psychologist, who regularly attended the unit and provided advice on how to care for prisoners. Although they had prepared useful care plans for long-term segregated prisoners, these were only shared verbally with staff running the unit and there were no written copies that staff could easily access to manage prisoners day to day.
- 3.37 Governance of segregation was weak and there had only been two segregation monitoring meetings since the pandemic started. Some useful data prepared for these meetings identified ongoing trends, such as the consistent over-representation of black and minority ethnic and Muslim prisoners among those segregated (see paragraph 4.33). Nothing had been done to investigate, understand or address these issues.

## Recommendation

- 3.38 **The regime in segregation should be improved so that all prisoners can have at least one hour's exercise, a shower and a phone call every day.** (Repeated recommendation 1.35).

## Security

Expected outcomes: Security and good order are maintained through an attention to physical and procedural matters, including effective security intelligence and positive staff-prisoner relationships. Prisoners are safe from exposure to substance use and effective drug supply reduction measures are in place.

- 3.39 As a local prison, there was a mix of unsentenced and sentenced prisoners categorised from A to D, which made the management of security procedures more complex. The prison held a large number of potential category A prisoners, mainly within the general population, and a small number of confirmed category A prisoners in a high secure unit (see below). Procedural and physical security arrangements were therefore thorough but mostly proportionate to the risks faced.
- 3.40 Leaders had been active in securing funding to combat identified shortfalls in the security function and it was now well resourced. Two dedicated staff had been appointed to manage gang issues, including the establishment of a database and logistical management of prisoners in conflict with each other. This positive initiative had great potential to reduce violence, although this work was not integrated with that of the safety team to maximise the opportunities available (see paragraphs 3.18–3.19).
- 3.41 A team of trained analysts were efficient in processing over 500 intelligence reports a month. The team had built on well-established HMPPS national intelligence assessment systems and now produced a weekly report that enabled the deputy governor and security managers to address emerging concerns effectively. This good practice enabled a more dynamic and immediate response to intelligence.
- 3.42 The establishment held several prisoners convicted under the Terrorism Act, in addition to those identified as holders of extremist ideologies. There were appropriate safeguards for these prisoners, who were monitored separately by a dedicated team. Prevention measures to manage the threat of staff corruption were also well established.
- 3.43 The risks associated with illicit substances had been identified as a key security objective and the governor had appointed a dedicated senior lead to oversee the establishment drug strategy. However, the drug strategy meeting lacked structure and was poorly attended, limiting the identification of actions to address and mitigate potential risks.
- 3.44 As part of the process of recovery from COVID-19, the use of mandatory drug testing had been reinstated, although data from testing

laboratories were yet to be published. Preliminary results from suspicion drug testing indicated that it was being used effectively and underpinned security intelligence.

- 3.45 The prison had access to a range of technology, including a body scanner, to combat security risks. These were used effectively to support the reduction of illicit items entering the prison, including drug-related paraphernalia.

### **High secure unit**

- 3.46 Most potential and confirmed category A prisoners were located within the general population, but Belmarsh remained the only high security prison holding high-risk category A prisoners separately. The high secure unit (HSU) had separate operating procedures and any allocation to the unit was authorised directly by the executive director for the long term high secure estate. (There are further references to conditions in the HSU in relevant sections, such as suicide and self-harm, living conditions and time out of cell.)
- 3.47 Generally, the relationships between staff and prisoners in the HSU were good, including the night support staff who had a good knowledge of the prisoners in their care. However, prisoners at risk of suicide and self-harm living on the HSU struggled to access appropriate support (see paragraph 3.58).
- 3.48 Prisoners on the HSU had the same meals as those provided in the rest of the prison, but, in contrast to most others, had access to a microwave and toaster and were able to prepare their own food.
- 3.49 The HSU regime provided daily access to exercise, domestic tasks and, in contrast to the main prison, association. If the full regime was delivered, prisoners could be out of their cells for most of the core day, but staff shortages meant this was often reduced. Instead, prisoners were offered a 'split regime', with prisoners on one spur locked up for half the core day while the regime was delivered on the other.

### **Safeguarding**

Expected outcomes: The prison provides a safe environment which reduces the risk of self-harm and suicide. Prisoners at risk of self-harm or suicide are identified and given appropriate care and support. All vulnerable adults are identified, protected from harm and neglect and receive effective care and support.

### **Suicide and self-harm prevention**

- 3.50 There had been four self-inflicted deaths since the last inspection. Prisons and Probation Ombudsman (PPO) investigations had led to an action plan to embed its recommendations. The recommendations directed to health care staff had been achieved, but some made to the prison, particularly on assessment, care in custody and teamwork

(ACCT) case management, needed urgent attention. The quality of prison manager investigations into serious attempts by prisoners to take their own lives was very poor. There was no evidence that staff and the prisoners involved had been spoken to, or that lessons had been learned and shared. (See key concern and recommendation 1.40.)

- 3.51 Recorded levels of self-harm were currently lower than at most similar prisons, but were nearly four times higher than at the previous inspection. The number of recorded incidents had initially reduced during COVID restrictions, but had doubled in the last six months. There had been 315 recorded incidents of self-harm, involving 94 prisoners, in the 12 months to June 2021.
- 3.52 Despite the concerning rise in incidents, leaders had not identified suicide and self-harm prevention as a key priority and there had been very little strategic planning. A written strategy and action plan provided to us during the inspection were about two years old and were not used actively to direct work or measure progress. Safer custody meetings were infrequent, poorly attended and did not address emerging trends.
- 3.53 The safer custody team had been given extra staffing for the duration of the pandemic. Its core task was to conduct welfare checks on about 200 prisoners identified as most at risk, including those subject to ACCT case management and, positively, all 18–21-year-olds (see paragraph 4.39). Aside from these welfare checks, other support for prisoners at risk of suicide and self-harm was limited. For the rest of the population, there were no regular well-being checks or key work (see Glossary), and most still spent the vast majority of their day locked in cell without purposeful activity (see paragraph 5.1).
- 3.54 Staff had struggled to implement the new version of ACCT, for which they had not received enough training. The number of prisoners subject to ACCT case management had increased to between 30 and 40 across the prison. The quality of support delivered through this process was weak. Care plans were missing or poorly completed. In one case, a prisoner with a very high risk of suicide and self-harm had been subject to constant supervision for months without having a care plan or support actions. Records of prisoners' interaction were often missing so it was impossible for case managers to see a complete picture of the individual's behaviour. Risk was not always assessed correctly. Case reviews for some prisoners were too infrequent. The weekly safety interventions meeting (see paragraph 3.20) discussed all prisoners subject to ACCT case management, but needed a clearer focus on developing and delivering actions to support prisoners at greatest risk. (See key concern and recommendation 1.40.)
- 3.55 We were not assured that prisoners subject to constant supervision (see Glossary) were always kept safe. During the inspection, a prisoner was left unsupervised in the bathroom while the officer sat further down the corridor reading a newspaper. Supervising staff worked 12-hour shifts, which was too long to allow for good concentration, and they did

little to encourage prisoners to interact and participate in anything purposeful. (See key concern and recommendation 1.41.)

- 3.56 There were enough Listeners, but more work was needed to promote the scheme. In our survey, only 44% of prisoners said that it was easy to speak to a Listener. Limited time out of cell meant that many prisoners never encountered Listeners. Access to a Listener was not built into the reception, first night or induction processes (see recommendation 3.13). Listeners told us that the pressure on staff to deliver so many separate regimes meant that they were sometimes unwilling to facilitate a call from a prisoner in distress. The Samaritans' regular debrief with Listeners about calls they had taken took place in residential association areas, which lacked privacy and was inappropriate.
- 3.57 Messages left on the safer custody hotline were only checked at the start of each day, which was not often enough to make sure that any urgent risk information from families was acted on promptly.
- 3.58 Prisoners at risk of suicide and self-harm living on the HSU (see paragraphs 3.46–3.49) struggled to access enough support. Listeners were unable to visit the unit. There were no in-cell phones and cordless Samaritans phones did not work on the unit. The only way these prisoners could call the Samaritans was on the landing phone, which lacked privacy and access.

#### **Protection of adults at risk (see Glossary of terms)**

- 3.59 Since the last inspection, leaders had identified the need to develop processes to make sure that prisoners at risk of harm, abuse and neglect were systematically identified and protected. Although an adult safeguarding policy had been developed, this had not been implemented and there were still no processes when we visited. It was unclear which manager currently held responsibility for this work and there was no record of any prisoners who had been identified as needing additional protection, nor any associated referrals. Leaders did not currently attend the local safeguarding adults board. Wing staff had not been trained to identify prisoners who were at risk of being easily exploited or abused.

#### **Recommendation**

- 3.60 **Prisoners defined as adults at risk of harm, abuse and neglect should be systematically identified and protected.**

## Section 4 Respect

**Prisoners are treated with respect for their human dignity.**

### Staff-prisoner relationships

Expected outcomes: Prisoners are treated with respect by staff throughout their time in custody and are encouraged to take responsibility for their own actions and decisions.

- 4.1 Relationships between staff and prisoners had improved since our last inspection. In general, staff we spoke to had a good knowledge of the prisoners under their care. We observed many positive interactions, with staff displaying a caring approach and ready to address day-to-day issues raised by prisoners. On some house blocks we also witnessed less engaging, but still functional, interactions between staff and prisoners. Generally good relationships between staff and prisoners were evident in the high secure unit.
- 4.2 Despite the positive relationships we observed during our visit, responses to our survey had not significantly improved in relevant areas since our last inspection. This suggested that there was still some way to go to develop consistently productive and supportive relationships between staff and prisoners. For example, only 58% of prisoners said staff treated them with respect. There were clearly still some staff whose approach to prisoners was not respectful and who displayed a lack of empathy or the necessary skills to contribute to a rehabilitative environment.
- 4.3 In our survey, only 29% of prisoners said that a member of staff had talked to them in the last week about how they were getting on, against the comparator of 44%. Key work had been suspended at the start of the pandemic and its absence undermined the development of productive relationships between staff and prisoners. An attempted resumption of key work in March 2021 had failed because of a further COVID-19 outbreak, but there were plans to relaunch at the same time as the planned move to level 2 of the recovery plan (see Glossary), tentatively scheduled to take place in the following month.

### Recommendations

- 4.4 **Staff should be trained and supervised to make sure that they relate with prisoners in a way that contributes to a rehabilitative culture.**
- 4.5 **Key work should be resumed at the earliest opportunity.**

## Daily life

Expected outcomes: Prisoners live in a clean and decent environment and are aware of the rules and routines of the prison. They are provided with essential basic services, are consulted regularly and can apply for additional services and assistance. The complaints and redress processes are efficient and fair.

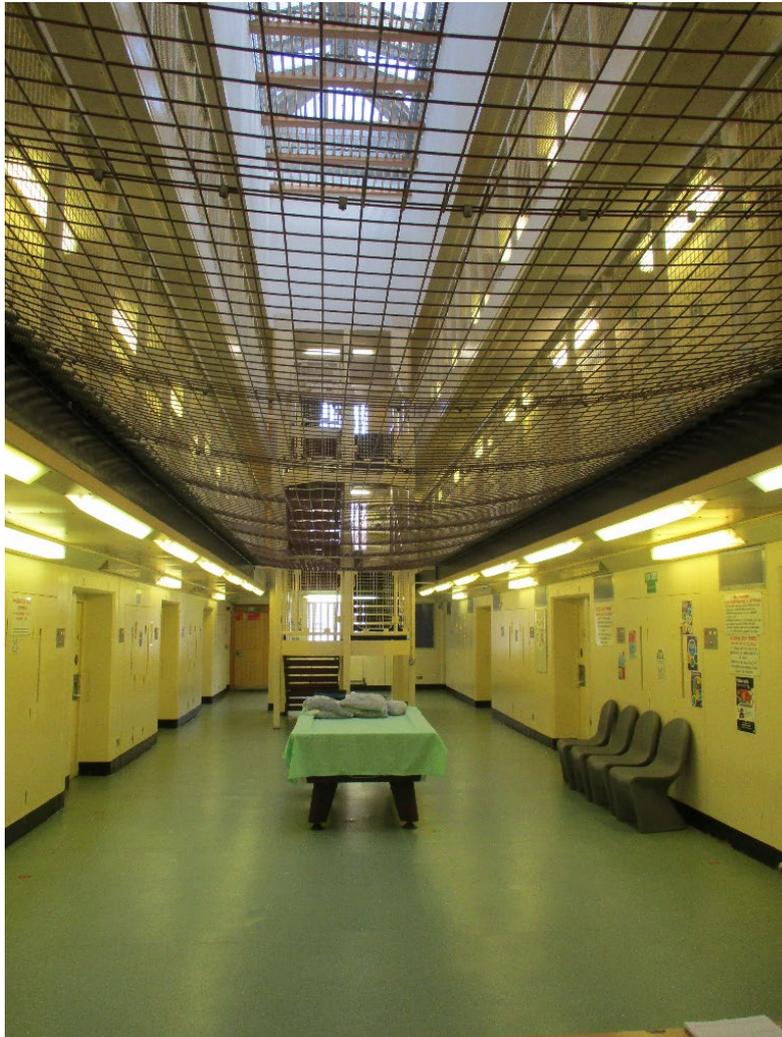
### Living conditions

- 4.6 Prisoners lived in single or double cells. Double cells were no longer used to accommodate three prisoners, as at previous inspections. The furniture in some cells was not in good condition and cell curtains were sometimes missing. Some cells were grubby, with poor paintwork in many.
- 4.7 Many communal showers on house blocks 1, 2 and 3 were in a poor condition, although there was a programme of works to replace them; new showers had been installed in house block 4.



**Shower on house block 3**

- 4.8 Other communal areas and facilities on the wings were generally clean. However, fire safety was still a problem; as in 2018, the equipment in most areas was locked in cabinets, and on house block 3 it was located behind two locked gates.



**Spur on house block 3**

- 4.9 The prison's aim to provide all prisoners with a daily shower was still not being achieved. In our survey, 40% of prisoners said they could shower every day, against the comparator of 89%, although this was an improvement from only 17% at our previous inspection.
- 4.10 Only 50% of prisoners, against the comparator of 67%, said they had access to cell cleaning materials each week. They also complained that the cleaning liquid provided was diluted and not always effective, particularly on the in-cell toilets. We were told that dilution was required given the category of prison. Deep cleaning of toilets was not frequent.
- 4.11 In our survey, only 38% of prisoners said that they were given clean sheets every week, compared with 78% in similar prisons. Some prisoners said that they sometimes had to wait several weeks to get clean sheets.

- 4.12 The living conditions in the high secure unit (HSU, see paragraphs 3.46-49) were generally reasonable, although it did get unpleasantly hot in the summer. The ventilation system was currently ineffective and recently installed windows did not allow air to flow in from outside. The portable air conditioning units in use were also not fully effective in reducing the temperatures across the unit, particularly in cells.
- 4.13 Outside areas were generally well maintained with several pleasant, well-tended gardens, although most prisoners had little access to them. Some areas outside the HSU were prone to flooding, which, along with an ongoing infestation by pigeons, made for an unpleasant and, potentially unhealthy, environment.
- 4.14 Most house block exercise yards were in reasonable condition and equipped with fixed exercise machines. The exercise yard on the HSU lacked such equipment, had no outlook, and was caged in and felt oppressive.



**Exercise yard**

- 4.15 Prisoners had long delays in getting their parcels sent or brought into the prison (see also paragraph 4.27). Remand prisoners said that one consequence of this was that they were not able to access suitable clothes for court appearances.

### **Residential services**

- 4.16 Only 36% of prisoners in our survey said the food was good. Provision was reasonable with suitable arrangements to cater for religious, cultural and medical diets. Breakfast packs were still issued the evening before. Lunch was a cold meal with only two choices; we were

told that options had been reduced during the restricted regime. The evening meal was better, offering five options.

- 4.17 Use of the few areas for communal dining had been restricted because of the pandemic and most prisoners ate in their cells. There were very limited opportunities for prisoners to prepare their own food, although some peer workers had access to microwaves and toasters.
- 4.18 Kitchen and wing serveries were clean and tidy. Prisoners working in these areas had completed basic food hygiene training and wore protective clothing.
- 4.19 There were effective consultation arrangements for catering, involving staff and prisoners. Meetings had been held even during the pandemic and there was evidence that catering staff adapted the menu as a result of prisoners' views.
- 4.20 While the prison shop service was reasonable, prisoners had experienced long delays in receiving catalogue orders. The prison had recently introduced measures for staff to track orders.

### **Recommendations**

- 4.21 **Prisoners should have access to clean sheets every week.**
- 4.22 **There should be a process to track and monitor the receipt of parcels and catalogue orders to make sure that prisoners receive their goods promptly.**
- 4.23 **There should be more opportunities for self-catering, particularly for enhanced-status prisoners.**

### **Prisoner consultation, applications and redress**

- 4.24 Consultation arrangements were good with forums enabling prisoners to influence some aspects of prison life. Prison 'community' meetings had resumed in February 2021 and were well attended. Prisoner representatives spoke positively about this meeting and provided examples of how it had led to changes. Other forums included house block meetings and consultation with the catering manager.
- 4.25 There were weaknesses in the applications process. In our survey, only 59% of prisoners said it was easy to make an application, compared with 77% in similar prisons. There was no oversight or tracking of applications and they were often not responded to. Only 24% of prisoners said their applications had been dealt with within seven days.
- 4.26 There had been just over 2,600 complaints in the last 12 months, which was lower than in similar prisons. Although we saw complaint forms on the residential wings, in our survey, only 46% of respondents said it was easy to make a complaint and only 28% of those who had made one thought they had been treated fairly.

- 4.27 Complaints were tracked to monitor completion, and a senior manager conducted monthly quality assurance checks and provided feedback to the investigating officers. Although complaints were regularly reviewed, some commonly raised issues had not been adequately addressed. For example, problems with receiving property had been the number one complaint in the year to date (see also paragraph 4.15 and recommendation 4.22), and most complaints had derived from house block 2. This ongoing pattern showed that progress was slow.
- 4.28 The sample of responses we viewed were mostly on time and respectful; where there were delays, the complainant was kept informed. The quality of responses was inconsistent. Some were not signed or dated, and others were not fully investigated.
- 4.29 There was no legal services officer or dedicated staff member to provide advice, signposting and support in this area. Prisoners did, however, have good access to legal visits and there had been a significant increase in the use of video link for judicial proceedings (see paragraph 3.1).

### **Recommendation**

- 4.30 **The applications system should provide prompt and helpful responses to prisoners, with tracking in place, and be subject to robust checks by managers.**

### **Equality, diversity and faith**

Expected outcomes: There is a clear approach to promoting equality of opportunity, eliminating unlawful discrimination and fostering good relationships. The distinct needs of prisoners with particular protected characteristics (see Glossary of terms) and any other minority characteristics are recognised and addressed. Prisoners are able to practise their religion. The chaplaincy plays a full part in prison life and contributes to prisoners' overall care, support and rehabilitation.

### **Strategic management**

- 4.31 There were substantial weaknesses in the delivery of equality work, with an out-of-date strategy and no multidisciplinary meeting to develop and drive action planning. As a result, the prison had not explored data highlighting disproportionate outcomes and there was no clear strategy to address issues. This was further compounded by limited consultation with prisoners with protected characteristics. (See key concern and recommendation 1.42.)
- 4.32 Although senior managers had been identified as leads for protected characteristic groups, work had not progressed, with only three meetings for black and minority ethnic prisoners and one for prisoners with disabilities over the last year. Minutes of these meetings were brief and lacked purpose. Equality peer representatives had been identified, but had no job description, training or purpose in their role. The lack of

a multidiscipline equality meeting meant there was no formal arena to which the representatives could report or develop their skills.

- 4.33 There was little monitoring data for most protected characteristics groups. The limited data collated showed, for example, the significant overrepresentation of Muslim prisoners in the use of segregation (see paragraph 3.37) and a higher number of younger prisoners being restrained (see paragraph 3.27), but the reasons for these variances were not explored or action taken to address disproportionate outcomes. The prison had not systematically monitored prisoner access to the very limited opportunities to work during the pandemic and did not know if prisoners in some protected groups had spent more time than others locked in their cells.
- 4.34 We were given different versions of the number of discrimination incident reporting forms (DIRFs) submitted in the last 12 months. The prison's database highlighted 50, which was higher than the number the prison provided us for the inspection. The quality of investigations into discrimination reports was mixed. Some forms were missing investigations or outcome letters, and some investigations were not thorough. That said, we did identify some good examples of investigation and resolution, such as a successful mediation between a prisoner and staff.

### **Protected characteristics**

- 4.35 In our survey, while black and minority ethnic prisoners made up more than half the population, only 42% said the prison shop sold the things they needed and only 29%, compared with 53% of white prisoners, said they could shower every day. Three meetings had been held with a small number of black and minority ethnic prisoners over the last year. Minutes of the meetings were brief and lacked meaningful discussion, and actions were not followed through. For example, there was no update on an action point from the December 2020 meeting to publish monthly statistics on job allocations at the next meeting, which was held seven months later.
- 4.36 Around 20% of the population were foreign nationals, but as no internal manager had been given responsibility for this group, support was poor. An immigration officer attended the prison twice weekly, but many foreign prisoners told us that they had not met them or had not been given any information on their immigration status. Prisoners had no access to free independent immigration advice and there had been no consultation with this group in over a year. Telephone interpreting services were not well used. There were no records or monitoring to make better use of the available services. We observed an absurd attempt to induct a non-English-speaking prisoner without the use of an official interpreter (see paragraph 3.7). However, printed induction information was provided in a good range of languages.
- 4.37 The prison identified that 14% of the population had a disability, which was substantially less than the 37% indicated in our survey. Only one consultative meeting had been held with this group in the last 12

months. Only one consultative meeting had been held with this group in the last 12 months. Records of the forum indicated few discussions about what it was like to be disabled at Belmarsh. There were no suggestions about how to improve access to services or day-to-day living and it was unclear what the meeting achieved. Twenty-five prisoners had a personal emergency evacuation plan (PEEP). Although these prisoners were identified on wing office notice boards, and while some staff could identify their needs, not a single house block could access the detailed plans. In some cases, the plans were missing from office folders. This meant that in an evacuation staff would not have been able to identify the needs of prisoners who required assistance. When we raised this, PEEPs were put into the folders the following day.

- 4.38 Prisoners over the age of 50 were mostly housed separately on house block 1. In our survey, these prisoners reported more positively in some areas: 90% said they could shower every day, compared with 38% of prisoners under 50, and 60%, against 13%, said they had good access to the dentist.
- 4.39 The prison's data showed that 15% of the population was under 21. Younger prisoners transitioning in from the young people's estate were given good support through a face-to-face or online introductory meeting with safer custody staff before they arrived at Belmarsh. The safer custody team visited younger prisoners each month to check on their welfare. This was better than we have found in many other prisons. However, staff were not specifically trained to deal with younger prisoners, there was little consultation with this group and no clear action to address disproportionate outcomes in the use of force that had been identified in monitoring data. In our survey, only 60% of prisoners under 25, compared with 82% of older prisoners, said there were staff they could turn to if they had a problem.
- 4.40 The prison's records showed that approximately 11% of prisoners were homosexual, bisexual or of another sexual orientation, which indicated a population of about 75 prisoners. However, there was little specific provision to support LGBT prisoners during the pandemic.
- 4.41 During our inspection, there were two transgender prisoners. Local case board meetings had been held for both prisoners and arrangements, such as showering separately, had been made in line with the local operating procedure. However, both prisoners said that they had not been provided with female clothing and make-up despite many requests evidenced in the board meetings.

## **Recommendation**

- 4.42 **The prison should consult prisoners in protected characteristics groups to understand and meet their specific needs.**

## Faith and religion

- 4.43 The chaplaincy had continued to provide good individual support to prisoners throughout the pandemic, although communal worship and religious education classes had been suspended for much of the period. To mitigate this, the chaplaincy had introduced Christian and Muslim prayer services by wing, which resulted in prisoners being able to attend service every five to six weeks. It was positive that the chaplaincy constructed its timetable around other activities, such as outdoor gym sessions and visits, but the return to a full chaplaincy service was slow.
- 4.44 The chaplaincy had continued to provide face-to-face support to prisoners, which started from the point of arrival. Chaplains were available for most faiths, with less common faiths covered by sessional or volunteer chaplains.
- 4.45 Facilities for corporate worship were suitable. The chapel was large and used for services for the larger faith groups, with a multi-faith room used for smaller groups.



**The chapel**

- 4.46 The managing chaplain was also the family liaison officer for the prison providing support after a death in custody; in one case, this included liaising with the Nepalese Embassy to arrange the cremation and the return of ashes following the death of a Nepalese prisoner.

## Health, well-being and social care

Expected outcomes: Patients are cared for by services that assess and meet their health, social care and substance use needs and promote continuity of care on release. The standard of provision is similar to that which patients could expect to receive elsewhere in the community.

- 4.47 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC found there were no breaches of the relevant regulations.

### Strategy, clinical governance and partnerships

- 4.48 Oxleas NHS Foundation Trust provided most health services at Belmarsh, subcontracted others, and was well led. Although the formal health needs assessment was out of date, the services in place broadly met the needs of patients. A new 'pathways' health needs assessment was being prepared to guide developments and plug any identified gaps in provision.
- 4.49 Partnership working with the prison, the NHS commissioner and the Greenwich cluster of prisons was mature and strong, supplemented by valued inputs from Public Health England during the COVID-19 pandemic. Governance systems were robust and there was evidence of learning from near-misses, serious incidents, deaths in custody, complaints and consultations with service users.
- 4.50 The numbers of serious incidents and complaints (an average of nine and 10 a month respectively) were low. The responses, mostly concerning minor issues in primary care, were timely, focused and polite.
- 4.51 In our survey, 49% of prisoners said the overall quality of health services was good, an improvement from 28% in at our previous inspection in 2018.
- 4.52 The management structure of the service had been enhanced since 2018 with clearer delegation and lines of accountability. A large team of registered nurses and support staff offered a 24-hour service, seven days a week. A new approach to bespoke staff development, led by a senior nurse, had been very positively received by health and prison staff. All the nurses we spoke to were content with their managerial and clinical supervision, and we saw good records. As recruitment of registered nurses was a constant challenge in London, vacancies were covered by bank arrangements and regular agency staff.
- 4.53 We observed good-natured and professional interactions between clinicians and patients, and nurses and pharmacy technicians knew most of their patients by sight.

- 4.54 Audits of SystmOne (the electronic clinical record) demonstrated appropriate usage and the problems associated with the system in 2018 had been addressed. The service was about to introduce GP-to-GP (a confidential electronic information transfer system) and Visionable (an NHS confidential electronic information exchange and meetings application), which were both likely to enhance continuity of care.
- 4.55 There was good management of communicable diseases, such as tuberculosis and COVID-19. Recent audits of infection prevention and control standards demonstrated high compliance (93% to 95%). The health centre and house block treatment rooms were kept clean, although some areas looked tired and needed refurbishment and decoration; managers were aware of these needs.
- 4.56 Since 2018, and as a result of learning, the service had adopted immediate life support (ILS) as its standard life-saving approach and 98% of clinicians were trained and in date with this. There were 13 bags of health emergency resuscitation equipment sited around the prison and those we sampled contained ILS and personal protective equipment (PPE). Twenty-five automated external defibrillators were sited strategically and accessibly. All emergency kit was checked weekly by Oxleas staff. There had been around two emergency calls a week for health care assistance in the last three months, although some were false alarms.

### **Promoting health and well-being**

- 4.57 The whole-prison approach to prisoner well-being had been disrupted during the COVID-19 restrictions, although health managers were considering a rejuvenated approach for when restrictions were lifted.
- 4.58 Health promotion in health and substance misuse services was good, although posters in the prison had been withdrawn early in the COVID-19 pandemic to minimise transmission of the virus. Health staff worked with the gym and kitchen to make sure patients' diets and medically required exercise encouraged their well-being.
- 4.59 Prisoners had access to age-appropriate immunisations and planning for autumn influenza vaccinations was under way. General uptake of the COVID-19 vaccine was in line with the community, but the take-up among prisoners under 40 was low at around 40%, which reflected the pattern among this age group in London. Nurses repeatedly visited younger prisoners to offer them vaccines.
- 4.60 National health screening programmes, such as bowel cancer, had resumed and, notably, the visiting MRI and ultrasound services had continued throughout the restrictions, as had local screening for diabetic retinopathy. Harm-minimisation advice and supplies were available on an individual basis.

## Primary care and inpatient services

- 4.61 Staff from Oxleas and Change Grow Live (CGL, see paragraphs 4.75 and 4.87) screened new arrivals in reception and on the first night wing and undertook a comprehensive health assessment within their first 72 hours. Referrals to other services were made as required. A senior 'well-being' nurse made sure that referrals were followed up by auditing SystemOne and holding weekly meetings, attended by clinicians from all departments, which held them to account until attributed actions had been completed. Commendably, all clinical teams engaged in early days screening, so that there was shared understanding of the pressures involved.
- 4.62 The wing-based service had been enhanced with diverse health activities, including nurse triage, GP and other clinics, which had enabled the continuation of care during COVID-19 restrictions. This was unlike the situation in the health centre, where some activities had been curtailed and patient attendance restricted.
- 4.63 Most primary care services in the health centre were back on stream and, as in 2018, were comprehensive. General and treatment clinics were run daily by nurses and GPs, who also provided monitoring clinics for long-term conditions such as diabetes and epilepsy. Visiting specialists offered hepatology, optometry, physiotherapy, podiatry and sexual health clinics.
- 4.64 On-site diagnostic X-ray facilities were available and no longer restricted to tuberculosis (as in 2018), which reduced the number of external hospital visits required.
- 4.65 As a result of the restrictions, the health service had become more accessible to patients because of greater use of technology. This included: in-cell telephone triage and welfare checks; the use of portable laptop computers to access SystemOne; wider use of remote hospital specialist appointments; and telemedicine (see Glossary). The care records and plans we sampled on SystemOne were good.
- 4.66 Patients could see a GP on the same day for an urgent consultation or within seven days for non-urgent appointments. Waiting lists for specialists were relatively short, such as two weeks for the physiotherapist and podiatrist, and three weeks for the optometrist. It was rare for patients to fail to attend for appointment, unlike the situation in 2018. Timetabled hospital appointments had increased from two to four a day, which provided enough capacity to meet routine demands.
- 4.67 Night nurses used the prison information system to identify patients being released and arrange pre-release consultations, take-home medicines, assistance to find a GP and information for GPs, as required.
- 4.68 The large 33-bed capacity inpatient unit had a comprehensive admissions policy, which permitted non-clinical admissions. While

practices had improved since 2018, the presence of non-clinical admissions continued to affect the unit's routine activities. Prisoners frequently arrived unwell from court requiring an admission to the inpatient unit. Effective communications with the Old Bailey court meant that most such admissions could be anticipated.

- 4.69 The unit had 22 patients, of whom 16 had mental health problems, including nine waiting for assessment or transfer under the Mental Health Act.
- 4.70 The inpatient care offered by Oxleas staff had been affected by severe staff shortages. However, these challenges were now abating, and there was strong leadership and oversight from a full-time service manager and psychiatrist. All inpatients had daily contact with clinical staff and their care plans were on SystmOne. Some patients had their weekly review face to face with the multidisciplinary team, which was positive. However, one-to-one medical in-confidence reviews of mental health patients were rare due to the risks associated with unpredictable behaviours and the lack of a suitable room. Most such interactions took place in the presence of prison officers, which reduced opportunities for psychological interventions and inhibited some disclosures that might have aided recovery planning.
- 4.71 A prison senior officer managed the inpatient unit well, aided by four prison staff. They were efficient in coordinating the complex movement of so many patients with disparate needs in a limited space. Officers working in health care knew the inpatients well and were effective in making sure that their needs were met as efficiently as possible.
- 4.72 Due to the unpredictability of the day and the changing needs of the inpatients, not all activities could be facilitated every day. Some inpatients did not always get both a shower and exercise each day, particularly due to the need for multiple unlocks, use of rooms by visiting clinicians and safety needs.

### **Recommendation**

- 4.73 **Admission to the inpatient unit should be for clinical reasons only.** (Repeated recommendation 2.57)

### **Social care**

- 4.74 The Royal Borough of Greenwich continued to commission a bespoke prisons social care service provided by CGL. Fifty-eight assessments had been completed from January to July 2021, of which 28 had met the threshold for a package of care and/or peer support. The service was widely advertised through posters and leaflets for both staff and prisoners. Prisoners were complimentary about the social care they received, which was exemplary.
- 4.75 Each prisoner had a care plan in his possession and the service manager held a more detailed account securely. Care delivery was

recorded comprehensively on prisoner records. Those requiring aids and equipment were assessed and Oxleas provided these promptly.

- 4.76 Social care peer support workers were trained, regularly supervised and did not undertake inappropriate intimate care. They could access advocacy services provided by POhWER (a charity providing advocacy, information and advice).

### **Mental health care**

- 4.77 Oxleas mental health services were delivered five days a week by a large team, with one member working on a Saturday to provide services for prisoners who had been at court during the week, which was valued. Support for patients with mild to moderate and enduring mental health problems was good.
- 4.78 There was open access to mental health services. Prisoners' immediate mental health needs were assessed through screening on their arrival, and they could refer themselves or be referred by health or prison staff. New referrals were reviewed daily, with urgent referrals seen within three days and non-urgent within 10 days. All referrals and patients were discussed at a daily multidisciplinary team meeting, with good psychiatric input. There were 60 patients on the caseload; most had complex formulations and all known health information was discussed at the meeting.
- 4.79 A psychology-led service supported patients with mild to moderate problems, such as anxiety and depression. It included a range of self-help material, such as for sleeping problems. Although no group work sessions were running at the time of inspection due to COVID-19 restrictions, there were plans to reintroduce groups in line with the easing of social distancing requirements.
- 4.80 Patients with severe and enduring mental health problems were supported appropriately by the care programme approach. There were clear pathways for care of patients with learning disabilities and complex behaviour. The mental health team was improving the pathway for supporting older prisoners.
- 4.81 The clinical records we viewed were clear, and demonstrated the use of risk assessments and a multidisciplinary approach to formulating care plans. Prescribing reviews and health monitoring for patients receiving mood stabilisers and antipsychotic medicines were completed regularly.
- 4.82 The mental health team helped patients plan for a release or transfer, and liaised with community teams and other prisons to arrange for continuity of support.
- 4.83 There were good links between the mental health team and the prison. Uniformed officers said they got some advice and guidance from the mental health team when needed, although few had received mental health awareness training in the last year due to the restrictions.

- 4.84 Sixteen patients had transferred to a mental health hospital under the Mental Health Act in the last six months. Most had waited longer than the current guideline of 28 days for transfer, which was unacceptable.

### **Recommendation**

- 4.85 **The transfer of patients to hospital under the Mental Health Act should occur within current Department of Health guidelines.**  
(Repeated recommendation 2.69)

### **Substance misuse treatment**

- 4.86 Psychosocial services were delivered by Pathways to Recovery (part of CGL) and were well led. CGL managers attended drug strategy meetings with the prison to help develop approaches to reducing demand and treatment for recovery. However, the full range of expertise offered by CGL in complementing soft intelligence and generating new strategies was underused.
- 4.87 CGL had an up-to-date policy for delivery of services. Psychosocial and clinical support for new arrivals with alcohol or drug problems remained good. In our survey, only 9% of prisoners said they had a drug or alcohol problem when they arrived at the prison, against the comparator of 23%, although around 200 prisoners (about 30% of the population) were in contact with CGL when we visited.
- 4.88 Prisoners had access to a range of relevant one-to-one and group-based interventions, with each having a care plan with individualised objectives towards recovery. Group work had been curtailed due to COVID-19 restrictions, although Pathways to Recovery had recently recommenced work in small groups that maintained social distancing. Groupwork included SMART (self-management and recovery training), cocaine and cannabis awareness, and brief interventions to address alcohol. At the height of the pandemic, CGL staff had provided prisoners with relevant in-cell packs, such as harm minimisation, drug awareness and skills for coping. CGL sent out newsletters and worked with the gym on a 'summer of sport' day encouraging all prisoners to get moving and enjoy exercise, despite the restrictive regime.
- 4.89 Oxleas delivered clinical support for patients. Doctors provided flexible prescribing based on individual needs, with 30 patients (4% of the population) receiving an opiate substitution treatment for maintenance or detoxification; we observed professional and safe administration of opiate substitutes. Clinicians and CGL drug recovery workers worked effectively as an integrated team to complete patient reviews after five days, 28 days and 13 weeks. Safe support for detoxification from alcohol was available as necessary. CGL staff worked well with the mental health team to share information and make sure patients had access to prompt support when needed.
- 4.90 CGL had trained four peer mentors based on the house blocks who offered support to new arrivals and helped run psychosocial support

groups. Patients requiring stabilisation were admitted to the stabilisation landing on the first night centre and received appropriate overnight treatment and monitoring.

- 4.91 Mutual aid groups, such as Alcoholics Anonymous and Narcotics Anonymous, had been unable to visit the prison due to COVID-19 restrictions, although an ex-prisoner was co-facilitating a group that enabled participants to learn from his experiences.
- 4.92 CGL provided prisoners with relevant community discharge plans for release. These included the 'Foundations of Me' family service programme, which supported prisoners to build relationships, develop parenting skills and improve life skills to enable them to settle back into the community. Vital help was provided to find accommodation, if needed, and signposting to sources of help upon release. Training in and provision of naloxone (to counteract the effects of opiate overdose) to take home was provided to patients who might benefit from its availability.

### **Medicines optimisation and pharmacy services**

- 4.93 Oxleas provided medicines in a safe and effective manner with medicines dispensed by the on-site, registered pharmacy.
- 4.94 About 65% of medicines were supplied in possession to prisoners (of which 40% were supplied weekly). There was a pertinent in-possession medicines policy. Patients' risk assessments were available at the time of prescribing. Medicines for the very low number of prisoners who did not hold them in possession were administered on the wings three times a day by a nurse or appropriately trained pharmacy technician. Patients requiring night-time medicines were risk-assessed and received a dose of medication in possession for use that night.
- 4.95 Most medicines were supplied as patient-named items with relevant labelling and dispensing audit trails. Items in the out-of-hours cupboard were pre-labelled by the pharmacy; conventionally, these items should be sourced from a supplier with an appropriate assembly licence, however the pharmacist was in discussions with the Medicines and Healthcare products Regulatory Agency about this practice. Medicines were provided as appropriate for prisoners on release from the prison.
- 4.96 Transfer of medicines from the pharmacy to the wings was secure. There was ample and safe storage space in the wing treatment rooms, which were generally clean and tidy. The temperature in the treatment rooms sometimes went above 25 degrees Celsius, but there were plans to install air conditioning to make sure medicines were stored at the right temperature.
- 4.97 Controlled drug management was good. There was auditing of prescribing including the use of tradable medicines, which was carefully monitored.

- 4.98 The pharmacy had a dispensing robot which prepared medicines in individual, labelled dose pouches. This was used to facilitate the supply of not-in-possession medication efficiently for patients receiving multiple medicines.
- 4.99 The medicines management committee met regularly and oversaw a full range of standard operating procedures and policies. Although no over-the-counter remedies were on sale from the prison shop, a few non-prescription medicines, such as ibuprofen and paracetamol, were available from the pharmacy shop. A range of emergency medicines and vaccines could be administered by nurses using patient group directions, authorising them to supply and administer prescription-only medicine. Even though medicines management clinics had been paused during the COVID-19 restrictions, 40% of prisoners in our survey said it was easy to see a pharmacist.

#### **Dental services and oral health**

- 4.100 NHS Dentists services and oral health promotion were very good, with sufficient capacity to meet the high demand and prompt access in an emergency.
- 4.101 Despite the continuing COVID-19 restrictions, the maximum waiting time for non-urgent appointments was two weeks, similar to pre-pandemic. A full range of evidence-based treatments were provided to meet the needs of remand and long-stay patients. Unlike in 2018, it was uncommon for patients not to attend their appointments.
- 4.102 The dental surgery was small but functional and, along with the decontamination room, was clean and well stocked. The area met infection-control standards and had enhanced air purification capability, which reduced the risk of contamination by airborne viruses. Equipment certifications and maintenance schedules were up to date.

## Section 5 Purposeful activity

**Prisoners are able and expected to engage in activity that is likely to benefit them.**

### Time out of cell

Expected outcomes: All prisoners have sufficient time out of cell (see Glossary of terms) and are encouraged to engage in activities which support their rehabilitation.

- 5.1 The prison had been running a restricted regime throughout the pandemic. Prisoners who were not working spent up to 23 hours a day locked in their cells. Our roll checks during the core day found only 23% prisoners engaged in out-of-cell purposeful activity and 52% locked up. (See key concern and recommendation 1.43.)
- 5.2 The prison aimed to provide daily outdoor exercise and this was generally delivered. However, the actual time prisoners spent outside varied between house blocks as a result of factors such as staffing levels. Most prisoners had around 45–50 minutes outdoor exercise each day, although some got as little as 30 minutes. (See key concern and recommendation 1.43.)
- 5.3 Association had not been available in the main prison since the restricted regime commenced in March 2020. Similarly, with the exception of PE, out-of-cell recreational activities were not generally available. (See key concern and recommendation 1.43.) However, the high secure unit (HSU) had its own regime that allowed daily time for association (see paragraph 3.49)
- 5.4 The library had closed at the beginning of the pandemic and, unlike in other prisons recently inspected, had neither reopened nor had plans or a timescale to do so. However, a selection of library books was available on the house blocks and there was a remote library service in which prisoners could request books via the applications process or through returning a slip directly to the library through the internal post. They could also request a range of other items, such as puzzles, word searches and greeting cards. A ‘virtual reading group’ had been set up where prisoners could write reviews of books to share with others; the librarians promoted the service through a monthly newsletter.
- 5.5 The remote library service was not as effective as we have seen in other prisons and did not provide a meaningful long-term alternative to physical access to the library. In our survey, only 14% of prisoners said that they could have library materials delivered to them once a week or more, compared with 27% in similar prisons.

- 5.6 The large and well-resourced gym had also closed at the beginning of the pandemic. The prison had taken this opportunity to refurbish the toilet and shower area, but the work was still far from complete when we visited. Even though prisoners had so little to do, the prison considered that it was not feasible to reopen the gym because of the lack of toilet facilities.
- 5.7 Physical exercise took place outdoors on the good-sized Astroturf area. Each spur in a house block had at least one session of PE a week, using outdoor equipment suitable for different weather conditions. Sixteen prisoners were able to attend each session. Sometimes, more than this number wanted to take part and decisions about who could attend were made on the house blocks. We spoke to prisoners who complained that access to PE was not fairly administered. Prisoners could also play football, although less frequently, at every two to three weeks.
- 5.8 There was also a small gym on house block 1, which provided an opportunity for exercise for enhanced-status prisoners and one with a disability who was not able to attend the outdoor PE sessions.
- 5.9 The HSU had a good-sized and well-resourced gym. However, because of staffing numbers, the facility was not currently in use. Some basic exercise equipment was available on the two spurs in use.

### **Recommendation**

- 5.10 **The prison should make sure that prisoners can immediately access the library and gym.**

### **Education, skills and work activities**



This part of the report is written by Ofsted inspectors. From May 2021 Ofsted began carrying out progress monitoring visits to prisons to assess the progress that leaders and managers were making towards reinstating a full education, skills and work curriculum. The findings and recommendations arising from their visit are set out below.

- 5.11 Ofsted assessed that leaders were making insufficient progress towards ensuring that staff teach a full curriculum and provide support to meet prisoners' needs, including the provision of remote learning.
- 5.12 Leaders and managers had been unable to provide education, skills and work to all but a handful of prisoners during the restricted regime. They had given out some in-cell work packs, but too many prisoners

had not participated in education in this way. Prisoners in the high secure unit did not have routine access to education.

- 5.13 New arrivals received an in-cell education induction pack, which included an initial assessment of their English and mathematics skills and the identification of any learning difficulties or disabilities. However, too many of these packs were not completed or returned. Prisoners whose literacy skills were at entry-level or who did not have English as their first language struggled to complete these packs. As a result, staff did not have sufficient information on which to allocate prisoners to education, skills or work.
- 5.14 Prisoners had recently started to benefit from one-to-one, face-to-face support. This supplemented the use of in-cell telephones and support provided through their cell door. However, while staff were able to phone prisoners, it was cumbersome for prisoners to call them for guidance or support, and so staff relied mostly on paper-based requests for support. This limited tutors' ability to provide prompt support.
- 5.15 A small number of prisoners had recently been able to sit examinations leading to qualifications in business and English. The number of accredited qualifications available to prisoners was too low.
- 5.16 Leaders and managers did not have an effective enough strategy to return to a full programme of education, skills and work. They had identified the education and skills programmes that they planned to implement. However, they did not adequately set out how they were going to return to classroom teaching or help prisoners catch up on learning that they had missed.
- 5.17 Leaders and managers had recently updated the prisoner pay policy to incentivise them to gain qualifications that would support them while in prison. However, due to the lack of accredited training available and the low numbers who participated in education and skills, it was not possible to determine the impact of this policy.
- 5.18 Staff from education, the prison and the newly appointed information, advice and guidance service worked effectively and had prioritised prisoners most in need of support; this included those whose first language was not English or whose release was imminent. This service was still in its infancy, but was starting to benefit the small number of prisoners who had accessed it.
- 5.19 Instructors in prison workshops planned and delivered training that was appropriate to meet the needs of prisoners. The training materials were of an appropriate standard, and were particularly good quality in the textile workshop, which had been operational for two months. Instructors referred effectively to techniques and concepts that allowed prisoners to extend their skills and knowledge.
- 5.20 Prisoners working in the textiles and packing workshops were able to explain what they had learned and, in a few cases, how they would

apply this once released. For example, those in the packaging workshop explained how their experience of leading tasks through to completion would be useful in warehouse work.

- 5.21 Prison staff had recently introduced a process for recognising and recording prisoners' personal development skills, such as teamworking, timekeeping and their approach to work. However, the process had yet to be extended to a significant proportion of prisoners.
- 5.22 Prisoners identified as having a learning difficulty or disability had started to receive individual face-to-face support. Tutors used the information they had on prisoners' needs to plan in-cell learning packs that supported them to overcome barriers to learning. For example, in-cell packs that promoted positive mental health and well-being were used for prisoners anxious about participating in education. Tutors had coloured overlays to support dyslexic prisoners and provided calculators to support prisoners develop their mathematical confidence.
- 5.23 A few prisoners had access to laptop computers to support learning in their cells. For example, those whose first language was not English could use a computer program to develop their communications skills, and prisoners who wanted to start their own business on release could access business related courses. This use of laptops motivated and engaged prisoners in learning.

### **Recommendations**

- 5.24 **The amount of classroom-based teaching available to prisoners should be rapidly increased.**
- 5.25 **There should be a rapid expansion in the number of prisoners from all areas of the prison who participate in education, skills and work.**
- 5.26 **More prisoners should complete and return the education induction packs, including the initial assessment, so that staff can provide support and allocate them to activities more effectively.**
- 5.27 **Staff in education, skills and work should support prisoners to develop their interpersonal skills and record these developments.**

## Section 6 Rehabilitation and release planning

**Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.**

### Children and families and contact with the outside world

Expected outcomes: The prison supports prisoners' contact with their families and friends. Programmes aimed at developing parenting and relationship skills are facilitated by the prison. Prisoners not receiving visits are supported in other ways to establish or maintain family support.

- 6.1 Work to help prisoners maintain relationships with their families had been severely curtailed during the restricted regime. The family strategy had not been updated to reflect changes resulting from COVID restrictions so it was not current. Despite the importance of family work, it did not feature on the agenda of the monthly reducing reoffending meetings. The manager responsible for family work attended prisoner consultation meetings but these forums were not used constructively to understand and discuss issues relating to the development of family relationships.
- 6.2 Visits had recommenced in May 2021 and take-up had been reasonably good. The visits hall was bright and spacious, but the children's play area and refreshment bar were still closed. It was positive that the prison now allowed physical contact during visits, and visitors had the option to complete a COVID test before arrival or at the visitors' centre. Most visitors we spoke to said they had been treated with respect, although some told us they had experienced lengthy delays contacting the booking line. Visit sessions were still limited to 45 minutes, and some visitors said this was a deterrent, but the prison had developed credible plans to increase availability when restrictions were eased further.



### Visits hall

- 6.3 The prison had been active in promoting the use of secure video calls (see Glossary) and take-up was one of the highest across all establishments. Prisoners could also use in-cell telephones, and in our survey 92% said they could use the phone every day, compared with just 19% in 2018. However, the prison limited calls to 10 minutes, which was disproportionate.
- 6.4 PACT (Prison Advice and Care Trust) continued to provide advice to families and held regular meetings with the operations manager, but had experienced difficulty in obtaining information from Belmarsh about which prisoners had children. Families had not been included in casework and there were no family interventions for prisoners, other than those with a substance misuse issue who worked with CGL (Change, Grow, Live, see paragraph 4.89).

### Recommendation

- 6.5 **The prison should involve families in casework and family interventions to support the rehabilitation of prisoners.**

## Reducing risk, rehabilitation and progression

Expected outcomes: Planning for a prisoner's release starts on their arrival at the prison. Each prisoner has an allocated case manager and a custody plan designed to address their specific needs, manage risk of harm and reduce the risk of reoffending.

- 6.6 The prison roll had reduced significantly since the previous inspection and the proportion of unsentenced prisoners had increased from 26% to 58.5%. Under the offender management in custody (OMiC) model (see Glossary), these prisoners were not allocated a prison offender manager (POM) and, following recent national changes, they now did not receive support from the resettlement team at the beginning of their time in custody when their jobs and tenancy were likely to be at risk.
- 6.7 The management of reducing reoffending work was not based on a recent needs analysis and the strategy document presented to us was purely a directory of services. The monthly reducing reoffending meeting did not cover all the resettlement pathways, notably families and significant others, and the minutes indicated almost no long-term actions. There was also no clear link between this meeting and the work of the offender management unit (OMU).
- 6.8 Belmarsh had fully implemented OMiC. The OMU was appropriately resourced with a senior probation officer (SPO) and head of OMU, as well as six probation POMs and seven prison officer POMs, supported by case administrators. It was positive that the SPO now provided regular casework supervision for all POMs. The SPO also gave clear guidance when allocating cases to the team, and prisoners assessed as presenting a higher risk were allocated appropriately to probation POMs.
- 6.9 POMs now had much lower caseloads than at the previous inspection (an average of 21 compared with 80 in 2018), although prison POMs were still being cross-deployed for operational duties. Levels of recorded contact between POMs and prisoners were not good enough, although we saw evidence that face-to-face contact had been taking place through most of the period of restrictions. However, the prison had not yet resumed key work, which was designed to complement the work of the POM.
- 6.10 POMs met newly sentenced prisoners to complete an offender assessment system (OASys) assessment, which included a risk management plan and a sentence plan to help them progress through their sentence. We regularly find that prisoners arrive at category B and C prisons to serve their sentence without an initial OASys completed at the sending local prison. It was, therefore, very positive that Belmarsh had decided not to transfer prisoners to other prisons until this assessment had been completed. As a result of the OASys hold protocol, there was only a very small backlog of assessments.

- 6.11 Despite this, in our survey only 20% of prisoners said they had a custody plan and only around a third of these said someone was helping them meet their targets. The prison should explore the reasons for these poor perceptions. OASys assessments were completed to a similar standard by both prison officer and probation POMs, and those we assessed were of a good quality.
- 6.12 There was effective contact between POMs and community offender managers, especially for release planning. However, there were some notable exceptions to this, and we found cases where delays in receiving a response from the community had led to some prisoners being released after their home detention curfew eligibility date.
- 6.13 At the time of the inspection, there were 84 indeterminate sentence prisoners at the establishment and POMs provided regular support for those eligible for parole.

### **Public protection**

- 6.14 At the time of the inspection, almost half of all sentenced prisoners (134) were assessed as posing a high or very high risk of serious harm. The release of all these prisoners was subject to regular scrutiny and guidance from the SPO.
- 6.15 There was good oversight of the 209 prisoners subject to multi-agency public protection arrangements (MAPPA). The monthly inter-departmental risk management meeting was well attended, including by some resettlement workers. MAPPA levels were set well in advance of a prisoner's release date, and there was effective communication between offender managers in the prison and stakeholders in the community about the specific risks that needed to be managed. POMs submitted information about prisoners to the MAPPA meeting in the community and the quality of the reports we inspected was reasonably good.
- 6.16 Dedicated public protection case administrators carried out an initial screening of the risks posed by each new arrival, including whether they should be subject to child contact restrictions or mail and phone monitoring, and the details of the assessment were added to a public protection database. Decisions to implement monitoring were authorised by an OMU manager, and those we reviewed were proportionate and well documented.
- 6.17 Case administrators shared details of prisoners subject to child contact restrictions with relevant departments, such as the mail room and visits. However, there was no oversight of phone monitoring arrangements and staff assigned to this task told us that the increase in call volume following the introduction of in-cell telephones meant it was difficult to meet demand. Monitoring staff were not managed within the OMU function and there was no clear ownership of this task. Leaders were surprised when we identified that calls by several prisoners had not been monitored for many weeks, and that some individuals had not been monitored at all.

## Recommendations

- 6.18 **The reducing reoffending strategy should be informed by a comprehensive and up-to-date population needs analysis.**
- 6.19 **All phone calls by prisoners covered by public protection monitoring should be listened to promptly to identify risk.**

## Categorisation and transfers

- 6.20 Following sentencing, prisoners were quickly allocated a security category and moved promptly to the most appropriate establishments to serve their sentence. In the previous year, over a third of all moves nationally of prisoners serving a life sentence were from Belmarsh.

## Interventions

Expected outcomes: Prisoners are able to access interventions designed to promote successful rehabilitation.

- 6.21 The prison delivered two accredited programmes; Resolve, which addressed violent offending for medium- to high-risk prisoners, and the thinking skills programme (TSP), a cognitive skills programme addressing offenders' thinking and behaviour. Although there was no recent needs analysis, the prison had a comprehensive programmes allocation database. Programme provision was appropriate, given that unsentenced prisoners were not eligible for accredited programmes and that the majority of sentenced prisoners moved promptly to other establishments.
- 6.22 No programmes had been delivered during the period of restrictions, although there were imminent plans to resume this work. The relatively quick turnover of the population meant that waiting lists were small and manageable with the resources available. The team had identified that referrals for programmes had reduced significantly after March 2020. There had been no investigation to understand and address this reduction. We saw evidence of proactive work by the programmes team to advance the onward transfer of a prisoner to facilitate participation in a programme not available at Belmarsh.
- 6.23 The psychology department had developed meaningful one-to-one work for a small number of prisoners who were unsuitable for programmes, for example, due to a learning disability. We also saw a positive example of work by this team with a prisoner convicted of a terrorism-related offence leading to the delivery of TSP on an individual basis.
- 6.24 The programmes team offered two motivational courses to encourage prisoners with a challenging custodial history to engage in offence-related programme work.

- 6.25 Prisoners working with the substance misuse team also benefited from interventions designed to improve communication, thinking and life skills, as well as how to develop coping mechanisms (see paragraph 4.88).

## Release planning

Expected outcomes: The specific reintegration needs of individual prisoners are met through an individual multi-agency plan to maximise the likelihood of successful reintegration into the community.

- 6.26 An average of 26 sentenced prisoners a month had been released in the previous 12 months and many more were released directly from court following a period on remand. The reception area had a supply of clothing donated by other prisoners that could be issued to prisoners being discharged if needed.
- 6.27 In our survey, only 38% of respondents due for release said that someone was helping them prepare. All new arrivals at the prison were seen by staff from the former London Community Rehabilitation Company (CRC) who completed an assessment of their needs and could make referrals as necessary, for example for advice on retaining a tenancy. However, since the end of June 2021, the CRC staff and their functions had been transferred to the National Probation Service and staff had been informed they could no longer make referrals or provide support to unsentenced prisoners, which was a significant loss of provision. (See key concern and recommendation 1.44.)
- 6.28 Resettlement workers saw sentenced prisoners 12 weeks before their release date to work with them to meet their identified needs. Resettlement workers were routinely invited to meetings such as the interdepartmental risk management meeting and safety interventions meeting, where risk associated with individual prisoners was discussed and could be taken into account during release planning.
- 6.29 However, some resettlement partners were still working remotely, such as the Department for Work and Pensions job coach, which impacted on the quality of the assistance provided. The prison had recently appointed Acorn as the new provider of the information, advice and guidance service. This followed termination of the previous contract, which had failed to assist all relevant prisoners with CV writing and preparation of disclosure letters.
- 6.30 The St Mungo's (homelessness charity) worker provided advice and guidance on accommodation. However, they could no longer provide this service to unsentenced prisoners during the early part of their time in custody when a tenancy was most likely to be at risk. In our survey, 61% of respondents said they needed help with accommodation on release. In the previous 12 months, 18% of sentenced prisoners who were released did not have an address to go to.

6.31 A dedicated 'care leaver' POM provided work with this group of prisoners and their personal adviser in the relevant local authority.

## Section 7 Recommendations in this report

The following is a list of repeated and new concerns and recommendations in this report.

### Key concerns and recommendations

- 7.1 Key concern 1.38: Levels of violence had continued to increase since the last inspection and too many prisoners felt unsafe. Despite available prison data, leaders did not analyse the indicators of violence in detail. The prison's strategy and associated action plan did not reflect the risks it faced and there had been no formal strategic meeting to address violence for over 18 months.

**Recommendation: Safety data should be used to inform a strategy and action plan to reduce increasing levels of violence, which leaders monitor and drive effectively.**

(To the governor)

- 7.2 Key concern 1.39: Governance of use of force had lapsed. Most incidents were spontaneous, but staff did not routinely activate body-worn video cameras. Despite good local data, there was no effective analysis or detailed scrutiny of force to make sure that incidents were necessary, justified and proportionate.

**Recommendation: There should be robust scrutiny of the use of force, including data, camera footage and staff statements, to make sure that force is necessary, justified and proportionate.**

(To the governor)

- 7.3 Key concern 1.40: The quality of case management support for prisoners at risk of suicide and self-harm was weak: risk was not always assessed correctly; some case reviews were too infrequent; and care plans were missing or poorly completed. Records of prisoners' interactions were often missing. It was clear that staff had struggled to implement the new version of ACCT.

**Recommendation: Prisoners at risk of suicide and self-harm should receive additional support through the use of good quality assessment, care in custody and teamwork (ACCT) case management that includes an accurate assessment of their risk, sufficiently frequent case reviews, appropriate support actions recorded in a care plan and a consistent record of their daily interactions.**

(To the governor)

- 7.4 Key concern 1.41: Constant supervision arrangements for prisoners at the highest risk of suicide and self-harm were unsafe. Staff read newspapers rather than observing the prisoners, who were also sometimes left unsupervised and unobserved. Supervising staff worked long shifts, which affected their concentration, and they did little to encourage prisoner interaction and participation in anything purposeful.

**Recommendation: Constant supervision arrangements should keep prisoners at risk safe and encourage them to engage with a purposeful regime wherever possible.  
(To the governor)**

- 7.5 Key concern 1.42: There were substantial weaknesses in equality work. The equality strategy was out of date and there was no multidisciplinary meeting to develop and drive action planning. There was limited consultation of prisoners in protected groups and little consideration of equality monitoring data.

**Recommendation: Equality data and effective consultation should inform an effective strategy and action plan that leaders drive proactively to address disproportionate outcomes for prisoners from protected groups.  
(To the governor)**

- 7.6 Key concern 1.43: Prisoners who were not working spent up to 23 hours a day locked in their cells. Only 23% prisoners were engaged in out-of-cell purposeful activity. Most prisoners had around 45-50 minutes outdoor exercise each day, although some got as little as 30 minutes. Association had not been available in the main prison since the restricted regime commenced in March 2020. The library remained closed and there were no developed plans to reopen it. Unlike in other prisons, the gym was still closed.

**Recommendation: The core day should provide adequate time out of cell for purposeful activity, domestic tasks and recreation to assist with the rehabilitation of prisoners and to improve their well-being.  
(To the governor)**

- 7.7 Key concern 1.44: The decision to stop resettlement workers providing advice and support to unsentenced prisoners was a significant loss to these prisoners, who made up almost 60% of the population. While the decision was outside the control of the prison, it had not put in place any measures to mitigate this.

**Recommendation: All prisoners, including those who are unsentenced, should be able to access resettlement advice and support to prepare them for their release into the community.  
(To HMPPS)**

## Recommendations

- 7.8 Recommendation 3.12: All new arrivals should have a private interview with a member of prison staff on their first night.  
(To the governor)
- 7.9 Recommendation 3.13: Listeners should be able to carry out their role throughout the reception, first night and induction processes.  
(To the governor)
- 7.10 Recommendation 3.14: Induction from peer workers should be overseen by a member of staff.  
(To the governor)
- 7.11 Recommendation 3.38: The regime in segregation should be improved so that all prisoners can have at least one hour's exercise, a shower and a phone call every day. (Repeated recommendation 1.35).  
(To the governor)
- 7.12 Recommendation 3.60: Prisoners defined as adults at risk of harm, abuse and neglect should be systematically identified and protected.  
(To the governor)
- 7.13 Recommendation 4.4: Staff should be trained and supervised to make sure that they relate with prisoners in a way that contributes to a rehabilitative culture.  
(To the governor)
- 7.14 Recommendation 4.5: Key work should be resumed at the earliest opportunity.  
(To the governor)
- 7.15 Recommendation 4.21: Prisoners should have access to clean sheets every week.  
(To the governor)
- 7.16 Recommendation 4.22: There should be a process to track and monitor the receipt of parcels and catalogue orders to make sure that prisoners receive their goods promptly.  
(To the governor)
- 7.17 Recommendation 4.23: There should be more opportunities for self-catering, particularly for enhanced-status prisoners.  
(To the governor)
- 7.18 Recommendation 4.30: The applications system should provide prompt and helpful responses to prisoners, with tracking in place, and be subject to robust checks by managers.  
(To the governor)
- 7.19 Recommendation 4.42: The prison should consult prisoners in protected characteristics groups to understand and meet their specific needs.  
(To the governor)

- 7.20 Recommendation 4.73: Admission to the inpatient unit should be for clinical reasons only. (Repeated recommendation 2.57)  
(To the governor)
- 7.21 Recommendation 4.85: The transfer of patients to hospital under the Mental Health Act should occur within current Department of Health guidelines. (Repeated recommendation 2.69)  
(To the governor)
- 7.22 Recommendation 5.10: The prison should make sure that prisoners can immediately access the library and gym.  
(To the governor)
- 7.23 Recommendation 5.24: The amount of classroom-based teaching available to prisoners should be rapidly increased.  
(To the governor)
- 7.24 Recommendation 5.25: There should be a rapid expansion in the number of prisoners from all areas of the prison who participate in education, skills and work.  
(To the governor)
- 7.25 Recommendation 5.26: More prisoners should complete and return the education induction packs, including the initial assessment, so that staff can provide support and allocate them to activities more effectively.  
(To the governor)
- 7.26 Recommendation 5.27: Staff in education, skills and work should support prisoners to develop their interpersonal skills and record these developments.  
(To the governor)
- 7.27 Recommendation 6.5: The prison should involve families in casework and family interventions to support the rehabilitation of prisoners.  
(To the governor)
- 7.28 Recommendation 6.18: The reducing reoffending strategy should be informed by a comprehensive and up-to-date population needs analysis.  
(To the governor)
- 7.29 Recommendation 6.19: All phone calls by prisoners covered by public protection monitoring should be listened to promptly to identify risk.

## Section 8 Progress on recommendations from the last full inspection report

### Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy prison. If a recommendation has been repeated in the main report, its new paragraph number is also provided.

#### Safety

##### Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2018, early days support was reasonably good overall. Levels of violence had increased since the last inspection, and some incidents were serious. More needed to be done to ensure the underlying reasons for poor behaviour were understood and addressed. The adjudications process was reasonable. Use of force was not high but de-escalation was not always evident. Segregation was not over-used and conditions were reasonable, but the regime was poor. Security arrangements were robust. The identification of and care for men at risk of self-harm was generally good. Outcomes for prisoners were reasonably good against this healthy prison test.

##### Key recommendation

The approach to violence reduction should identify and address the underlying reasons for poor behaviour. Both perpetrators and victims of violence should receive support to ensure violent incidents are prevented in the future. (S36)

##### Not achieved

##### Recommendations

First night interviews should be carried out in a confidential setting. (1.12)

##### Not achieved

The IEP scheme should be applied consistently and fairly across the prison. (1.20)

##### Achieved

Adjudication data should be collated and analysed more rigorously to ensure charges are fair and punishments appropriate. (1.23, repeated recommendation 1.61)

##### Achieved

Wing staff should routinely use body-worn cameras and spontaneous use of force should be recorded wherever possible. (1.28)

##### Not achieved

Governance of use of force should improve and include an assessment of whether de-escalation was sufficient. (1.29)

**Not achieved**

The regime in segregation should be improved so that all men can have at least one hour's exercise, a shower and a phone call every day. (1.35)

**Not achieved** (recommendation repeated, 3.40)

All prisoners' complaints about staff misconduct should be logged and appropriately investigated by a suitably independent manager. (1.41)

**Achieved**

The role of the HSU should be clarified and decisions to locate men there should be clear and transparent and open to independent scrutiny. Prisoners should be able to appeal a decision. (1.45)

**Achieved**

Formal investigations should be commissioned following serious near fatal incidents of self-harm to ensure lessons are learned. (1.52, repeated recommendation 1.38)

**Not achieved**

Care plans in ACCT documents should be reviewed and updated and action should be implemented. (1.53)

**Not achieved**

There should be a working Samaritans phone on each wing and Listeners should be available to men who ask for them. (1.54)

**Not achieved**

## **Respect**

### **Prisoners are treated with respect for their human dignity.**

At the last inspection, in 2018, staff-prisoner relationships were mixed. Some staff were excellent but too many discipline staff were dismissive and disrespectful towards prisoners. Conditions in units were adequate, but the cells holding three men were very cramped and few prisoners could shower every day. The food was adequate but meals were served too early. Consultation arrangements were good, but prisoners were frustrated because they were unable to get some everyday issues resolved. Equality and diversity work needed leadership and a re-launch to ensure all needs could be identified and, where possible, met. Health care provision was good, and social care and psychosocial support for prisoners' substance misuse problems were excellent. Outcomes for prisoners were not sufficiently good against this healthy prison test.

## **Key recommendations**

Managers should ensure all staff know what is expected of them. Staff should receive suitable training and be held to account through supervision and observation. (S37)

**Partially achieved**

The prison roll should be reduced so that double cells are no longer used to hold three men. (S38)

**Achieved**

The governor should ensure equalities and diversity work is sufficiently prioritised so prisoners' needs can be identified and, where possible, met. (S39)

**Not achieved**

## **Recommendations**

All prisoners should be able to shower every day. (2.9, repeated recommendation 2.10)

**Not achieved**

The multi-faith room should be redecorated to ensure appropriate worship areas are provided for all faiths. (2.37)

**Achieved**

Health care complaints should be treated confidentially and be subject to quality assurance. (2.48)

**Achieved**

Admission to the inpatient unit should be for clinical reasons only. (2.57)

**Not achieved** (recommendation repeated, 4.74)

The transfer of patients to hospital under the Mental Health Act should occur within current Department of Health guidelines. (2.69)

**Not achieved** (recommendation repeated, 4.86)

Medicines should always be stored safely. (2.82)

**Achieved**

## **Purposeful activity**

**Prisoners are able, and expected, to engage in activity that is likely to benefit them.**

At the last inspection, in 2018, time out of cell had been reduced significantly since our last inspection, and was poor for many prisoners. Managers attempted to ensure men had a regular period of association every day. Ofsted rated education, skills and work activities inadequate. Managers had a good understanding of the problems faced and developed plans for improvement. However, the number of activity places had declined, the range was too limited and there was not enough work. Few

prisoners could gain work-related skills or qualifications to help them obtain employment after release. Given the needs of the population, it was particularly worrying that the prison lacked sufficient funding to meet educational needs. Attendance and punctuality needed to improve. Pass rates for those who did complete a course were good. Outcomes for prisoners were poor against this healthy prison test.

### **Key recommendations**

The regime should ensure men have sufficient time out of cell each day, and adequate access to outside exercise. (S40)

#### **Partially achieved**

The number, quality and range of purposeful activity places should be sufficient to meet the needs of the men held and should prepare them for employment on release. (S41)

#### **Not assessed at this inspection**

### **Recommendations**

Library provision should be timetabled to ensure prisoners have regular access, including at weekends. (3.14)

#### **Not achieved**

A broad range of recreational and vocational opportunities should be available to all prisoners who use the gym, including those with protected characteristics. (3.15)

#### **Not achieved**

Managers should encourage the development of work discipline by ensuring that prisoners attend their activities regularly and on time. (3.24)

#### **Not assessed at this inspection**

The education provider should promote and support prisoners' participation in open and distance learning courses to enhance their qualifications and skills. (3.25)

#### **Not assessed at this inspection**

Managers should ensure that all prisoners whose skills in English and maths are assessed as being below level 1 are encouraged to improve their skills by attending appropriate classes. (3.26)

#### **Not assessed at this inspection**

Leaders and managers should monitor prisoners' progress after release to evaluate the success of resettlement activities. (3.27)

#### **Not assessed at this inspection**

Managers should increase English and maths provision in prison workplaces. (3.37)

#### **Not assessed at this inspection**

Managers should ensure that teachers plan learning activities that meet the different needs of prisoners in the class, including the most able. (3.38)

**Not assessed at this inspection**

Managers should develop the Personal Skills Development Scheme so that all prisoners in prison work can participate. (3.44)

**Not assessed at this inspection**

Managers should improve retention on education courses. (3.51)

**Not assessed at this inspection**

## **Rehabilitation and release planning**

**Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release back into the community.**

At the last inspection, in 2018, the children and families provision had been improved and prisoners had a range of opportunities for contact with family members. Offender management arrangements did not ensure all prisoners had an up-to-date assessment or custody plan, and most prisoners did not have sufficient contact with offender supervisors. Higher risk men and those with complex problems were well managed. Public protection arrangements were strong. Some good accommodation and substance misuse support was provided. Pre-release planning often started too late and the work needed to be better integrated. Outcomes for prisoners were reasonably good against this healthy prison test.

## **Recommendations**

Robust arrangements should be put in place to ensure visitors do not experience unnecessary delays when attempting to book visits. Arrangements should be tested regularly by a senior manager and action to address identified shortfalls fully documented. (4.8)

**Achieved**

Visiting arrangements for men in the HSU should be enhanced in line with those available to mainstream prisoners. (4.9)

**Partially achieved**

All offender supervisors should have regular professional supervision and casework reviews to aid personal development, and quality assurance should be extended across all offender management work. (4.25, repeated recommendation 4.16)

**Achieved**

Sentence plan targets should be specific and focus on reducing prisoners' risks. (4.26)

**Achieved**

Prisoners should be transferred promptly to a prison able to offer the range of interventions necessary to reduce their risk of harm. (4.27)

**Achieved**

The prison should develop a policy to address domestic violence so perpetrators are identified and appropriately engaged to reduce their risk of reoffending. It should also cover any child protection concerns. (4.33)

**Partially achieved**

All sentenced prisoners should have a clear resettlement plan outlining all work that has been undertaken to reduce the risk of reoffending and any outstanding issues. It should include work covered by all departments, not just those delivered by the CRC. (4.38)

**Achieved**

## Appendix I About our inspections and reports

Her Majesty's Inspectorate of 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.

All inspections 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.

All Inspectorate of Prisons reports carry a summary of the conditions and treatment of prisoners, based on the four tests of a healthy prison that were first introduced in this Inspectorate's thematic review *Suicide is everyone's concern*, published in 1999. For men's prisons the tests are:

### **Safety**

Prisoners, particularly the most vulnerable, are held safely.

### **Respect**

Prisoners are treated with respect for their human dignity.

### **Purposeful activity**

Prisoners are able, and expected, to engage in activity that is likely to benefit them.

### **Rehabilitation and release planning**

Prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release into the community.

Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by Her Majesty's Prison and Probation Service (HMPPS).

### **Outcomes for prisoners are good.**

There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

### **Outcomes for prisoners are reasonably good.**

There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

**Outcomes for prisoners are not sufficiently good.**

There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

**Outcomes for prisoners are poor.**

There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

Our assessments might result in one of the following:

**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.

**Recommendations:** will require significant change and/or new or redirected resources, so are not immediately achievable, and will be reviewed for implementation at future inspections.

**Examples of notable positive practice:** innovative work 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.

Five key sources of evidence are used by inspectors: observation; prisoner and staff surveys; discussions with prisoners; discussions with staff and relevant third parties; and documentation. During inspections we use a mixed-method approach to data gathering and analysis, applying both qualitative and quantitative methodologies. Evidence from different sources is triangulated to strengthen the validity of our assessments.

Other than in exceptional circumstances, all our inspections are unannounced and include a follow up of recommendations from the previous inspection.

All inspections of prisons are conducted jointly with Ofsted or Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council (GPhC). Some are also conducted with HM Inspectorate of Probation. This joint work ensures expert knowledge is deployed in inspections and avoids multiple inspection visits.

## **This report**

This report provides a summary of our inspection findings against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 5, 2017) (available on

our website at <https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/>). The reference numbers at the end of some recommendations indicate that they are repeated and provide the paragraph location of the previous recommendation in the last report. Section 7 lists all recommendations made in the report. Section 8 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of prisoners and a detailed description of the survey methodology can be found on our website (see Appendix II: Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

### **Inspection team**

This inspection was carried out by:

Charlie Taylor	Chief inspector
Deborah Butler	Team leader
Ian Dickens	Inspector
Martyn Griffiths	Inspector
Lindsay Jones	Inspector
David Owens	Inspector
Christopher Rush	Inspector
Nadia Syed	Inspector
Jonathan Tickner	Inspector
Charlotte Betts	Researcher
Annie Bunce	Researcher
Alec Martin	Researcher
Jed Waghorn	Researcher
Paul Tarbuck	Lead health and social care inspector
Tania Osborne	Health and social care inspector
Peter Gibbs	Pharmacist
Lynda Day	Care Quality Commission inspector
Bev Gray	Care Quality Commission inspector
Steve Lambert	Ofsted inspector
Nigel Bragg	Ofsted inspector
Rebecca Jennings	Ofsted inspector

## Appendix II 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.justiceinspectors.gov.uk/hmiprison/about-our-inspections/>

### **Care Quality Commission (CQC)**

CQC is the independent regulator of health and adult social care in England. It monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety. For information on CQC's standards of care and the action it takes to improve services, please visit: <http://www.cqc.org.uk>

### **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.

### **Close supervision centre (CSC)**

Holds prisoners under prison rule 46, which allows the removal of the 'most significantly disruptive, challenging and dangerous' prisoners from the ordinary prison system into conditions that are managed centrally by HM Prison and Probation Service (HMPPS).

### **Community rehabilitation company (CRC)**

From May 2015, rehabilitation services, both in custody and after release, were organised through CRCs, responsible for work with medium- and low-risk offenders. The National Probation Service (NPS) maintained responsibility for high- and very high-risk offenders. Following a change in policy, all offender management was brought under the NPS on 28 June 2021.

### **Constant supervision**

Used to observe prisoners deemed at high risk of self-harm and in crisis.

### **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.

### **Leader**

In this report the term 'leader' refers to anyone with leadership or management responsibility in the prison system. We will direct our narrative at the level of leadership which has the most capacity to influence a particular outcome.

### **Offender management in custody (OMiC)**

The Offender Management in Custody (OMiC) model, being rolled out across the closed male prison estate, entails prison officers undertaking key work sessions with prisoners (implemented during 2018–19) and case management, which established the role of the prison offender manager (POM) from 1 October 2019.

### **Personal protective equipment (PPE)**

Safety equipment including masks, aprons and gloves, worn by frontline workers during the COVID-19 pandemic.

### **Protected characteristics**

The grounds upon which discrimination is unlawful (Equality and Human Rights Commission, 2010).

### **Protection of adults at risk**

Safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs); and
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse and neglect (Care Act 2014).

### **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 to the least as they ease COVID-19 restrictions. (<https://www.gov.uk/government/publications/covid-19-national-framework-for-prison-regimes-and-services>)

### **Secure video calls**

A system commissioned by HMPPS, which requires users to download an app to their phone or computer. Before a visit can be booked, users must upload valid ID.

### **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).

**Telemedicine**

The practice of caring for patients remotely when the provider and patient are not physically present with each other.

**Time out of cell**

Time out of cell, in addition to formal 'purposeful activity', includes any time prisoners are out of their cells to associate or use communal facilities to take showers or make telephone calls.

## **Appendix III Further resources**

Some further resources that should be read alongside this report are published on the HMI Prisons website (they also appear in the printed reports distributed to the prison). For this report, these are:

### **Prison population profile**

We request a population profile from each prison as part of the information we gather during our inspection. We have published this breakdown on our website.

### **Prisoner survey methodology and results**

A representative survey of prisoners is carried out at the start of every inspection, the results of which contribute to the evidence base for the inspection. A document with information about the methodology and the survey, and comparator documents showing the results of the survey, are published alongside the report on our website.

### **Prison staff survey**

Prison staff are invited to complete a staff survey. The results are published alongside the report on our website.

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