Report on an unannounced inspection of

HMP Durham

by HM Chief Inspector of Prisons

15 and 22–26 November 2021

Contents

Introduction

Largely rebuilt in 1881, HMP Durham is a men's category B reception prison that accepts prisoners from across the north of England. At the time of our inspection there were 959 prisoners, of whom 606 were on remand. More than a third of the prison's population were receiving support for substance misuse.

Much credit must go to the impressive governor and to what was a generally strong leadership team, who had worked together to reduce the supply of drugs into the prison. This had contributed to a more than 60% fall in violence since our last inspection, making the prison one of the safer locals in the country. Throughout the inspection the prison felt calm and generally well-ordered.

We also saw a commensurate fall in the use of physical intervention, but during the inspection we uncovered some examples of staff appearing to use force in improper and disproportionate ways. Leaders needed to take urgent action to make sure that staff were sufficiently trained and had effective systems for reviewing incidents.

Like most local prisons the jail had a large population of prisoners who came in with often serious mental health difficulties or who misused drugs or alcohol. This meant that, particularly in their first days in custody, they could be at risk of suicide or self-harm. We were therefore concerned that late in the evening or at particularly busy times, the prison was not able to offer full health care screenings to new arrivals. These prisoners often had to be dispersed around the jail because the induction unit was full, which meant they did not always get the care and the attention they needed.

The quality of health care in every area, from GP appointments to mental health provision, was suffering from some serious staff shortages. Prisoners frequently complained to inspectors about the difficulties in getting treatment or medication. These issues were compounded by problems with the application system that meant prisoners could not submit a second application to a department before a previous application had been resolved – for example, a prisoner who had put in an application for a visit could not make an application to see the GP until the visit had been agreed. This issue also impacted on family contact: slots for visits remained unfilled, with families often only being told the day before that there was an available time.

Many prisoners remained locked in their cells for too long, particularly those on the induction wing. The prison could have done more to provide activities and work, but they were hampered by an education provider that had been slow to restore services.

The prison had worked to refurbish much of the indoor and outdoor communal areas in this historic prison, but many cells were overcrowded and dilapidated. While staff from the former community rehabilitation company continued to provide some support to prisoners on remand, the future of this provision was uncertain with the reunification of probation services. This and the fact that the senior probation officer was leaving to be replaced by a temporary appointment,

meant the provision of resettlement work and sentence planning was fragile. Inspectors were very concerned that 43% of prisoners left the jail without suitable accommodation.

Durham prison has showed some impressive improvements since our last inspection and the governor and his team should be proud of the progress the jail has made, particularly considering the challenges caused by the pandemic. The inspection team left optimistic that if senior leaders remain in post and the issues raised in this report are addressed, the prison can continue to make good progress.

Charlie Taylor
HM Chief Inspector of Prisons
January 2022

About HMP Durham

Task of the prison
A reception prison for adult and young adult men, with a small resettlement function.

Certified normal accommodation and operational capacity (see Glossary of terms)
Prisoners held at the time of inspection: 959
Baseline certified normal capacity: 600
In-use certified normal capacity: 578
Operational capacity: 980

Population of the prison
- 5,000 new prisoners received in the previous year (around 420 per month).
- 62% of prisoners are on remand.
- 120 foreign national prisoners.
- 12% of prisoners from black and minority ethnic backgrounds.
- Around 140 prisoners released into the community each month.
- 348 prisoners receiving support for substance misuse.
- 96 prisoners with complex mental ill health being supported.

Prison status (public or private) and key providers
Public

Physical health provider: Spectrum Community Health CIC
Mental health provider: Tees, Esk and Wear Valleys NHS Foundation Trust
Substance misuse treatment provider: Humankind
Prison education framework provider: Novus
Escort contractor: GEOAmey

Prison group
Tees and Wear

Brief history
Opened in 1819 and rebuilt in 1881, Durham prison's primary role from May 2017 was as a reception prison holding adult men aged 21 and over and young adults aged 18 and over. It serves the courts of Tyneside, Teesside, Durham and Cumbria.

Short description of residential units
A, B, C D wings – general population
E wing – first night and induction unit
F wing – vulnerable prisoner unit
Integrated support unit (ISU) based on I wing (11 beds and two cells for cleaners) for prisoners with significant mental health problems
G wing – segregation unit
Health care inpatient unit – six beds

Name of governor and date in post
Phillip Husband, August 2018

Prison Group Director
Alan Tallentire

Independent Monitoring Board chair
Therese Quincey

Date of last inspection
24 September – 5 October 2018

Section 1 Summary of key findings

1.1 We last inspected HMP Durham in 2018 and made 55 recommendations, five of which were about areas of key concern. The prison fully accepted 45 of the recommendations and partially (or subject to resources) accepted nine. It rejected one recommendation.

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 Durham 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 four recommendations about key concerns in the area of safety. At this inspection we found that three of those recommendations had been achieved and one had been partially achieved.

1.5 We made one recommendation about key concerns in the area of rehabilitation and release planning. At this inspection we found that this recommendation had not been achieved.

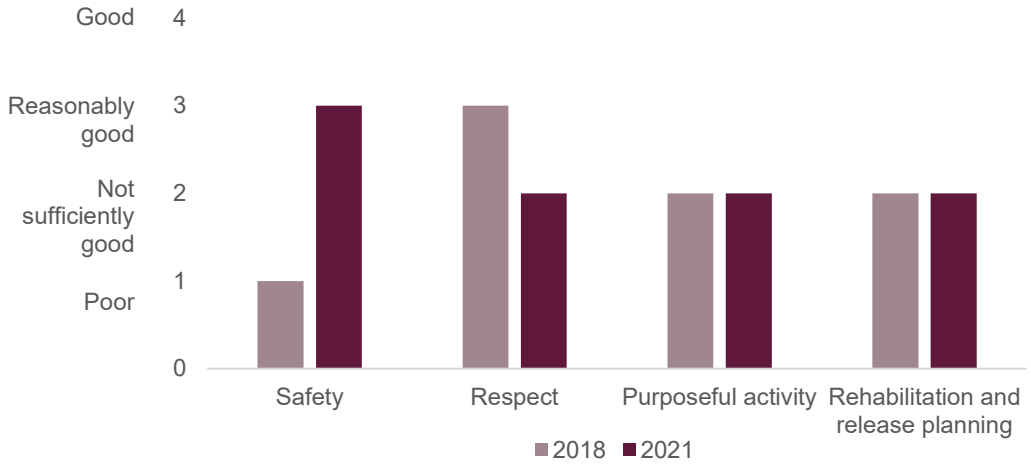
Outcomes for prisoners

1.6 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).

1.7 At this inspection of Durham we found that outcomes for prisoners had stayed the same in two healthy prison areas, improved in one and declined in one.

1.8 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 Durham healthy prison outcomes 2018 and 2021



Safety

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

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

1.9 Reception was a busy environment. Staff were welcoming but late admissions affected the quality of provision. There was good opportunity for new arrivals to discuss any anxieties or concerns as a robust vulnerabilities assessment was completed on admission. The first night centre was also busy and at times this resulted in a lack of action on important requests from prisoners, and the regime was not good enough. Population pressure meant that many prisoners spent their first night on other wings, creating additional risk. First night cells were unwelcoming, and some were missing essentials, such as pillows or blankets. Induction was weak and many prisoners did not receive key information.

1.10 Work to improve security and reduce the supply of drugs and associated violence had been successful. Violence had fallen by 61% since the last inspection and the number of incidents was low. The monthly safety meetings were effective and examined a wide range of data, which were used to inform the violence reduction strategy and take appropriate actions. Weekly safety intervention meetings focusing on individual prisoners and incidents also led to useful actions. Plans to challenge perpetrators and support victims of violence were undermined by poor targets and a lack of engagement from frontline officers.

1.11 Use of force had reduced by 69% since our last inspection and was low. The monthly use of force meetings discussed relevant data, but scrutiny of CCTV footage required improvement. We saw several examples of poor practice during use of force and referred these to managers for further investigation. Unfurnished accommodation had

been used 20 times in the last year. Records were poor and did not always justify its use.

1.12 Use of segregation remained similar to the last inspection. The reasons for segregation were not always documented appropriately. At the time of our inspection, two prisoners had been in the segregation unit for over 100 days. There was an absence of reintegration planning, which frustrated prisoners we spoke to. Cells were bare; many lacked tables and chairs. The regime was poor.

1.13 There had been five self-inflicted deaths since our last visit. There was evidence that the prison had taken action in response to Prisons and Probation Ombudsman recommendations following investigations into these. Recorded levels of self-harm were lower than similar prisons and were on a downward trend. There was good interrogation of self-harm data at the monthly safety meeting. The quality of support delivered through assessment, care in custody and teamwork (ACCT) case management for at-risk prisoners varied. Most we spoke to were positive about the care they received; however, care maps were poorly completed and staff records of daily interaction with prisoners were often missing. Changes in risk levels were not always explained. Staff supervising prisoners on constant supervision did little to encourage purposeful interaction and participation for them.

Respect

At the last inspection of Durham 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 were now not sufficiently good.

1.14 In our survey, two-thirds of prisoners said that they were treated with respect by staff and those we spoke to were generally positive. The key worker scheme was operating better than we have seen in similar establishments. We observed mostly positive interactions, including some effective staff challenge of low-level poor behaviour.

1.15 Over three-quarters of prisoners were living in crowded conditions. The standard of cells needed improvement; many were poorly ventilated, lacked furniture and some were in a state of disrepair. Some showers were also in poor condition and not adequately screened. The cleanliness of communal and outside areas was good.

1.16 The number of complaints had reduced since our last inspection and was low. Responses to complaints did not always address the issues raised, particularly when the complaint was about staff. The electronic kiosk applications system was well used, but it had restrictions that were a frustration for prisoners. Prisoner consultation arrangements were good and led to positive change.

1.17 Leaders did not have a complete picture of prisoners with protected characteristics and were therefore not able to make sure their needs were met. Consultation with protected characteristic groups had not yet resumed, although equality representatives for each wing had recently been appointed. Many prisoners were not aware of how to report discrimination. Some prisoners who struggled to speak English were overlooked. There was promising work to support younger prisoners. Corporate worship and faith-based study classes had resumed.

1.18 Prisoners who arrived late did not receive health care reception screening and health care risk management was not sufficient to ensure patient safety. Staffing shortages were having a detrimental impact on the provision of health care in all areas. There were 264 prisoners on the waiting list for the GP, with the longest wait at eight weeks, and there was no evidence of risk management in the clinical records. An audit of medicines management had identified that medications were frequently not available, there was a failure to follow-up patients who did not collect their medication and poor record-keeping. Officer supervision of medication queues continued to be inconsistent or absent. The quality of dental provision was good, although waiting times were too long.

Purposeful activity

At the last inspection of Durham 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 remained not sufficiently good.

1.19 Time out of cell varied from about 30 minutes a day in the open air for prisoners on the reverse cohort unit (RCU) to 6.5 hours for fully employed prisoners. Leaders had started a programme that increased prisoners' time out of cell under the new regime delivery plan. Our roll checks found that 56% of prisoners were locked behind their doors during the core day and 25% were at work or in out-of-cell education. Prisoners who worked full time were not offered exercise on weekdays. The library provision was reasonably good and supported literacy initiatives. The gym timetable was too restrictive and it was underused.

1.20 Leaders had a clear and appropriate curriculum plan for education, skills and work, but the return to face-to-face education and vocational training workshops was slow. While there were sufficient activity places in the plan, a combination of staff shortages and unavailability of facilities meant that too many prisoners were not benefiting from purposeful activity.

1.21 Prisoners who attended education, skills or work worked well in a calm and respectful environment. However, attendance was too low and prisoners were not routinely punctual at activities.

1.22 Prisoners in full-time wing work did not benefit from the planned development of skills or acquisition of vocational qualifications. Some were not busy enough and would have benefited from combining work with in-cell learning, but this option was not available.

1.23 The availability of full-time jobs and additional responsibilities on the wing were a disincentive to prisoner participation in education. During the COVID-19 restrictions, the induction and allocation process had not operated effectively and a large backlog of prisoners needed to complete the induction.

1.24 The quality of education was not consistently good. There were some areas of strength in creative community projects (IT), social enterprise, 'think family' and horticulture courses. However, the quality of education in English for speakers of other languages (ESOL) and multi-skills required improvement. With the support of peripatetic tutors, prisoners in work made good progress in English and mathematics.

1.25 Where prisoners with learning difficulties and disabilities were assessed, they made good progress. However, there was a backlog of prisoners with additional needs awaiting assessment who had yet to benefit from the available support.

Rehabilitation and release planning

At the last inspection of Durham 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 remained not sufficiently good.

1.26 The prison had three family workers who provided valuable support to prisoners.

1.27 The visits booking system was in disarray with delays in processing applications, resulting in many prisoners missing their entitlement, including prisoners on remand.

1.28 The reducing reoffending action plan was focused on COVID-19 recovery and did not link to any offender management strategy or action plan. There was limited provision to meet the resettlement needs of the significant number of unsentenced prisoners. Backlogs in the court system meant that many of these prisoners were released having served their time.

1.29 The quality and timeliness of most offender assessment system (OASys) assessments that we viewed were good, but there was little management oversight or quality assurance. Recording of contact with prison offender managers was poor; about half the cases we viewed did not record any contact.

1.30 Most prisoners had regular key work sessions, but these were focused on their welfare rather than progression and sentence planning. Risk management plans were good, and we saw some good communication with community offender managers for managing potential risk on release.

1.31 Home detention curfew was well managed with most prisoners released on time.

1.32 Categorisation decisions were timely and appropriate. Most prisoners were moved within 10 days of sentence.

1.33 Public protection arrangements were good. The dedicated team collated critical risk management information on high-risk prisoners effectively despite the high turnover of the population.

1.34 Before release, the inter-departmental risk management team considered prisoners with complex issues appropriately. The monitoring of phone calls and mail for prisoners who posed a risk was managed well and there was no backlog.

1.35 The resettlement team assessed the needs of every prisoner irrespective of status within five days of arrival, which was positive. The release plans that we viewed were good. Records showed that 43% of sentenced prisoners and nearly all remand prisoners who were directed for release left Durham without suitable accommodation, including some prisoners regarded as high risk.

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: Due to population pressures, prisoners usually arrived into an environment at the prison that was chaotic and busy, and were allocated to wings not equipped for providing an introduction to Durham. Some new arrivals went into cells that were not adequately furnished, missing basic items such as pillows and blankets or with torn or worn-out mattresses. The early days regime was poor and induction did not cover essential information about life at Durham.

Recommendation: All aspects of prisoners' arrival into the establishment should be effective and fit for purpose, including standards of accommodation and the quality of induction and regime.
(To the governor)

1.39 Key concern: Review of use of force footage was inadequate and in several incidents, leaders had missed actions by staff that needed to be addressed. Much of the footage we observed had been recorded inadequately and provided limited scope to observe clearly what had taken place.

Recommendation: Leaders should make sure that all use of force is necessary and proportionate.
(To the governor)

1.40 Key concern: Governance of the segregation unit was weak and we were not assured that segregated prisoners would be kept safe. The justification for segregating prisoners, especially those on at-risk case management or with mental health concerns, was not always documented appropriately and safety screens were not reviewed routinely.

Recommendation: Prisoners should be kept safe at all times while segregated, and their needs should be recognised and given proper attention.
(To the governor)

1.41 Key concern: The prison was overcrowded, with over three-quarters of prisoners living in cramped conditions, sharing cells designed for one. Most shared cells did not have adequate screening to the toilet or sufficient lockable cabinets. Many cells had insufficient furniture and equipment, and some were in a state of disrepair.

Recommendation A: Prisoners should not live in overcrowded conditions.
(To the governor)

Recommendation B: Cells should be equipped and furnished to a decent standard.
(To the governor)

1.42 Key concern: The prison did not have a complete picture of prisoners with protected characteristics. Data were incomplete and had not been reconciled with those from various sources across the prison. Analysis of data was rudimentary and mostly limited to ethnicity and age.

Recommendation: Leaders and managers should use data to construct a clear picture of prisoners with protected characteristics in order to meet their needs.
(To the governor)

1.43 Key concern: Significant staffing shortages had had a detrimental impact on the delivery of primary care, mental health and pharmacy services, with long delays for routine GP appointments and mental health assessment, and the absence of reviews of ongoing treatment and prescribed medicines.

Recommendation: The prison should work with NHS England and NHS Improvement to make sure there are sufficient health care staff to meet the health needs of the population, in line with national guidelines.
(To the governor)

1.44 Key concern: The late arrival of prisoners into reception meant that not all received a first night reception health care screening. This created the risk that the health needs of new arrivals were left unassessed before they were transferred to their cells.

Recommendation: All new arrivals should receive a first night health care reception screening before they are moved to the induction wing.
(To the governor)

1.45 Key concern: Prisoners were prioritising full-time work on the wings, where they were not explicitly developing and recording skills, at the expense of education and vocational training.

Recommendation: The delivery of education, work and skills should allow for a combination of face-to-face and in-cell learning to engage more prisoners in purposeful activity, and the activities, allocations and pay policies should be aligned to motivate prisoners to work towards their long-term goals.
(To the governor)

1.46 Key concern: Prisoners with needs for provision in English for speakers of other languages were not receiving the quality of education they needed and too many were not getting any support at all.

Recommendation: Leaders should assess, meet the need and improve the quality of provision in English for speakers of other languages.
(To the governor)

1.47 Key concern: The visits booking process was failing. Applications from prisoners to arrange a visit were being processed two weeks after they had been submitted and many prisoners told us they could often get no more than one visit a month, including prisoners on remand who were entitled to three visits a week.

Recommendation: Managers should make sure that prisoners can access the visits they are entitled to.
(To the governor)

1.48 Key concern: Some remand prisoners spent long periods in custody due to backlogs in the courts. There was little in place to support these prisoners or occupy them while in custody, and their resettlement needs were not assessed or met.

Recommendation: Managers should assess the needs of the remand population to make sure appropriate support is provided while they are in custody and after release.
(To the governor)

1.49 Key concern: Nearly all prisoners due for unplanned release and 43% of all sentenced prisoners released, including some high-risk prisoners, did not have suitable housing to go to.

Recommendation: Prisoners should have suitable and stable accommodation on their release.
(To the governor)

Notable positive practice

1.50 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.

1.51 Inspectors found one example of notable positive practice during this inspection.

1.52 Prisoners held in segregation under the secreted items policy were seen by psychosocial practitioners daily to encourage engagement with their service and to provide education on the potential risks associated with having secreted items. (See paragraph 4.87.)

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 Durham was a generally well-led establishment with a stable leadership team. The effective governor had been in post since the previous inspection and was supported by an experienced senior leadership team. He had a clear vision of a safe and decent establishment, and had set appropriate, measurable priorities in his self-assessment report to support this. In our staff survey, most respondents agreed with these priorities. At the previous inspection, we made four key recommendations in the area of safety and at this visit we judged that three had been achieved. Most leaders were aware of remaining deficiencies and had plans to address them.

2.3 The governor was a visible presence around the prison and communicated well with both staff and prisoners through daily staff briefings, in-cell television appearances and written updates. Leaders undertook regular walk-arounds in residential areas and there was clear evidence that this had led to improved standards on the wings. In our staff survey, most respondents reported that leaders and managers set high standards and challenged poor behaviour by staff.

2.4 Consultation with prisoners was good and led to meaningful change. This was conducted through regular meetings with peer workers as well as prisoners selected at random to take part in discussions about a particular aspect of life a Durham. It was commendable that this had been maintained throughout the COVID-19 pandemic.

2.5 At the time of our inspection, progress in the governor's priority areas was mixed. There had been significant reduction in the use of drugs and improvement in decency, but prisoners' experience of their first night and early days required substantial improvement, and recovery in education, skills and work had been too slow.

2.6 The work to reduce the supply of drugs and the impact of this on safety was impressive. Joint working between security, drug strategy and safety managers had resulted in a considerable reduction in violent incidents and disorder, which were now far lower than the average for category B local prisons.

2.7 During our inspection, we saw the impact of late arrivals and population pressures at Durham. Prisoners who arrived late did not receive health

care screenings. A lack of space also meant that prisoners already at Durham were moved to the segregation unit to free up beds for new arrivals who, too often, spent their first night in poorly prepared cells in inappropriate locations around the prison. Local managers needed support from national leaders to resolve the issue of late arrivals, out-of-area prisoners and population pressures to reduce risks during prisoners' first few days at Durham. Oversight of the segregation unit and scrutiny of use of force incidents also required improvement.

2.8 Acute staff shortages in health care meant services were frail and operated with substantial risks. The head of health care was aware of the shortcomings and had begun to make improvements, but this continued to be a key concern.

2.9 Leadership in rehabilitation and release planning was fragmented and delays in the court system affected outcomes for prisoners on release.

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 a busy environment with a very high turnover of prisoners at Durham. In the last year, there was an average of 426 new arrivals a month, with a further 417 who passed through reception to attend court, transfer elsewhere or be released. Due to population pressures at other establishments, the prison regularly received new arrivals who would have ordinarily gone to prisons in the North West of England.

3.2 As a result of a large catchment area and staffing constraints with the escort provider, GEOAmey, prisoners often arrived together and late in the day, which affected the quality of provision that the prison could offer. For example, on the first day of our inspection, 28 prisoners arrived from 5pm onwards and in close succession, which placed pressure on staff and involved long waits for prisoners, both in court cells and on arrival. This was not uncommon and, in such circumstances, not all new arrivals received a health screen, which increased risk (see also paragraph 4.56 and key concern and recommendation 1.44).

3.3 Reception staff were welcoming and completed a robust and comprehensive vulnerabilities' assessment on admission, which also considered historical self-harm, and arrivals had good opportunity to discuss any anxieties or concerns in private. The holding rooms for new arrivals were sparse with little information about the prison. A daily stability report monitored the rationale for decisions on the support for prisoners with self-harm concerns. This positive step addressed concerns that had been raised previously by the Prisons and Probation Ombudsman (see paragraph 3.35).

3.4 Interpreting services were available for prisoners who did not speak English and basic reception information had been translated into the five main languages spoken at Durham.

3.5 Although the prison used non-intrusive searching technology during admissions, such as a body scanner, all new arrivals were also routinely strip searched, regardless of risk. The entrance to the search area was not sufficiently private for those being searched.

3.6 No formal peer support was offered in reception. Although a Listener (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) employed as a reception worker was available, this was not embedded as a part of the reception process.

3.7 New arrivals were transferred on to the first night centre (E wing), which was used as a reverse cohort unit (RCU, see Glossary of terms) for their first 14 days. Additional safety checks were completed in the first 24 hours. This centre was exceptionally busy and, as a result, important requests from prisoners were not actioned. For example, because of a lack of action from staff, a newly arrived prisoner requested that inspectors intervene to get in touch with his dying father; it was his eighth day at Durham with no contact. Within an hour of requesting support, the chaplain informed the prisoner that his father had died.

3.8 Due to population pressures, many prisoners spent their first night and early days quarantining on other wings, including, inappropriately, the unit for prisoners with severe mental health needs (see paragraph 4.71). This created unnecessary risk both in relation to COVID-19 and because these units were not prepared for new arrivals and struggled to find time for them. (See key concern and recommendation 1.38.)

3.9 The regime on the RCU unit was not good enough, and prisoners in their early days spent too long locked in their cells with little purposeful activity (see paragraph 5.2).

3.10 First night cells were unwelcoming and were not properly cleaned in between occupants. Some were missing essentials, such as pillows and blankets, and many mattresses were in very poor condition. Although new arrivals were given an initial supply of basic items, they could not order from the prison shop for up to two weeks (see paragraph 4.15 and recommendation 4.17). (See key concern and recommendation 1.38.)

First night cell on E wing

3.11 Induction was weak and many prisoners did not receive key information. However, the induction officer attended reception to meet new arrivals and escorted them to the wing. Although this meeting included exploration of the vulnerabilities assessment (see paragraph 3.33), it provided limited information about daily life and what to expect. There was no formal induction the next day and we found many prisoners who were unaware of how to use the electronic information kiosk, which was the main method for accessing services. (See key concern and recommendation 1.38.)

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

3.12 Since our last inspection, incidents of violence had decreased considerably. In the previous 12 months, there had been 198 incidents, compared with 492 in the same period before the last inspection – a

61% reduction - and the proportion categorised as serious had halved. Much of this decrease had happened before regime restrictions were introduced at the start of the pandemic, as the prison had made a concerted effort to tackle the supply of illicit substances, a major contributor to the violence levels. In our survey, significantly fewer prisoners than at our previous inspection told us that they had experienced verbal abuse, physical assault, threats or intimidation, or theft of canteen or property.

3.13 Most vulnerable prisoners were separated from mainstream prisoners and were accommodated on F wing. Those we spoke to said that staff looked after them well, although across the prison, support for victims of violence was underdeveloped.

3.14 Monthly safety meetings were effective, analysing a wide range of data to monitor patterns of violence, informing the violence reduction strategy and enabling managers to take swift action. Links between the safer custody and security departments remained a strength.

3.15 Weekly safety intervention meetings were well attended and an effective forum for discussing how to manage individual perpetrators of violence. Challenge, support and intervention plans (CSIPs, see Glossary) were raised for some prisoners who posed a risk to others or required more specific support, and were tracked by a custodial manager. At the time of the inspection, seven prisoners were being monitored through this process. All violent incidents were referred for investigation. If staff did not recommend opening a CSIP as a result, they were required to provide written justification for why and explain how perpetrators of violence would be managed otherwise, which was good. Despite this, further work was required to embed the CSIP process on residential units where many frontline officers were not aware of prisoners' plans, and targets were often generic.

3.16 The incentives policy was based on standard HMPPS policy and there had been limited creativity to motivate and encourage prisoners. The basic level of the scheme had been suspended for much of the pandemic and had only recently been reintroduced. At the time of our inspection, only four prisoners were on the basic level.

Recommendation

3.17 **Challenge, support and intervention plans (CSIPs) should be used effectively for perpetrators of violence and contain meaningful targets of which both prisoners and staff who engage with them each day are aware.**

Adjudications

3.18 There had been 1,074 adjudications in the last 12 months, which was four times lower than at the previous inspection. Around 20% had been dismissed or discontinued. Those that we sampled had been terminated appropriately, demonstrating laudable procedural fairness to prisoners, and we were assured that adjudications were conducted

proportionately. The backlog of incomplete hearings was low, and the prison had good links with the police to monitor progression of serious matters that had been referred to them for investigation.

3.19 Leaders had reasonably good oversight of adjudications and made sure that only the most serious of charges were heard. Recently recommenced monthly meetings scrutinised relevant data on protected characteristics. The deputy governor conducted monthly quality assurance checks of 10% of adjudications and provided valuable feedback to adjudicators, which reinforced consistency and fairness to prisoners.

Use of force

3.20 Use of force was 69% lower than at the last inspection and almost half the level at similar prisons. In the last 12 months, force had resulted in the use of control and restraint techniques (used by officers and staff to physically restrain prisoners) in 280 incidents, averaging around 24 a month. Batons had been drawn eight times but used on three occasions. The incapacitant spray PAVA had been drawn once but not used.

3.21 Very few use of force incidents were planned and 77% in the last 12 months were spontaneous. Oversight of baton and PAVA use was very good. Senior managers examined all incidents involving the drawing of or use of PAVA or batons and gave us clear examples of action taken when staff actions fell short of required standards. The monthly use of force meeting viewed all incidents where an injury had been sustained, batons or PAVA had been drawn or a concern had been referred.

3.22 Despite these systems, we had concerns about poor practice and potentially illegitimate use of force in several incidents we reviewed. These were referred to managers for further investigation.

3.23 Although staff routinely collected and used body-worn cameras for planned interventions, the footage was not always clear, and this needed to be viewed in combination with that from CCTV to understand incidents better. Briefings and debriefs following planned control and restraint had been missed or not taken place; we raised this with leaders during the inspection who gave assurance that this would be addressed. Health care staff were not always present to monitor the prisoner's health while they were restrained. (See key concern and recommendation 1.39.)

3.24 Management of use of force paperwork and data collation had improved significantly. The monthly use of force meeting considered relevant data and took appropriate action in response to any concerns. Weekly use of force meetings had commenced recently to provide additional oversight. Although it was too early to assess their impact, we noted that there was very minimal use of force documentation outstanding that needed to be completed by staff, and it was clear that leaders had worked hard to address this. Use of force training had

continued despite the pandemic, and 94% of staff were up to date and refreshed in C&R techniques.

3.25 Management scrutiny of the use of unfurnished accommodation was weak. The two cells had been used 20 times in the last 12 months. Written documentation for seven of these uses was missing and so we were unable to calculate the average length of time prisoners stayed in these conditions. The justification recorded for unfurnished accommodation use was not always clear or proportionate, there was little evidence that it had been used as a last resort and record-keeping of staff observations of prisoners was deficient.

Unfurnished accommodation in segregation unit

Recommendations

3.26 **Planned use of control and restraint should be recorded clearly on hand-held camera and all footage, including CCTV, should be retained as part of the review process.**

3.27 **Health care professionals should attend all planned incidents of use of force and make sure the prisoner is monitored while under restraint, providing medical advice to the staff when required.**

Segregation

3.28 The use of the segregation unit was similar to the last inspection. There had been 662 uses in the previous 12 months with an average stay of six and a half days. At the time of inspection, around two-thirds of the segregation unit cells were occupied; around half of these prisoners had been segregated after the body scanner indicated they may be secreting illicit items. Three prisoners lived on the segregation unit full time, working as orderlies. At the time of inspection, two prisoners had been in the unit for over 100 days.

3.29 The daily regime on the segregation unit was too limited. Prisoners were unlocked one at a time and received a maximum of one hour out of their cells each day, including 30 minutes outside. The exercise yards were bleak, with three out of the four empty and only one containing a solitary piece of exercise equipment. Prisoners were not permitted to associate or exercise together and received little meaningful contact. Daily chaplaincy visits sometimes took place through cell doors, which was unacceptable. The cells on the segregation unit were bare and some lacked basic furniture, such as tables and chairs, and toilet seats.

Segregation unit yard

3.30 Governance of the use of segregation was weak and justification for segregating prisoners for reasons other than being suspected of secreting illicit items was not always documented appropriately. The decision logs for prisoners on assessment, care in custody and teamwork (ACCT) case management for risk of suicide or self-harm were poor. It was particularly concerning that we were unable to locate the paperwork and approval for two prisoners who had been

segregated against health care advice. Safety screens were also not routinely reviewed when it had been deemed necessary to continue segregation, which increased the risk of missing individual needs or a decline in mental health. There was an absence of reintegration or exit planning, which frustrated some prisoners we spoke to. (See key concern and recommendation 1.40.)

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.

3.31 Since our last inspection, the prison had made significant efforts to improve security and reduce the supply of drugs and associated violence. The prison now had a body scanner, additional CCTV, a dedicated searching team and enhanced gate security on entry to the prison. This work was effective.

3.32 Although intelligence-led suspicion drug testing had continued at low levels throughout the pandemic, the return and subsequent prioritisation of random mandatory drug tests (MDTs) in October 2021 meant that only one intelligence-led drug test had taken place in the previous six weeks. This was a weakness that had the potential to undermine the drug supply reduction strategy.

3.33 Physical security arrangements were generally proportionate and aligned to identified risks, but some procedural security was disproportionate (see paragraph 3.5).

3.34 The security department had received 3,958 intelligence reports in the previous six months. These were collated, analysed and disseminated promptly, but actions were not tracked so managers were unaware of the outcomes of security actions, including searches.

3.35 As at the last inspection, security-led meetings examined a wide range of data. Security objectives and priorities were based on intelligence and reflected the key risks to prison security. The security and safety departments worked closely together, alongside a new head of drug strategy. Links with the police remained good, and inter-agency work helped in the management of identified extremists.

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

3.36 There had been five self-inflicted deaths since our last visit, four of which were between January and July 2020. The prison monitored recommendations from the Prisons and Probation Ombudsmen (PPO) investigations following the five deaths through an action plan. There was clear evidence that some actions had been addressed, particularly in identifying and supporting at-risk prisoners on arrival (see paragraph 3.3). However, the plan was not fully up to date with all PPO recommendations and required better oversight. The PPO action plan was still not a standing agenda item in key prison meetings, although we were told at our last visit that this would happen.

3.37 It was more positive that recorded levels of self-harm had reduced over the previous 12 months and were lower than in 2018. The rate of self-harm was on a downward trend and the number of incidents was lower than for similar prisons.

3.38 The new version of ACCT case management for at-risk prisoners had been introduced earlier in 2021 with some face-to-face training. The quality of support delivered through ACCT case management varied, despite a process for quality assuring documents. Most prisoners we spoke to were generally positive about the care they received, but we found some fundamental gaps in casework. Care maps were poorly completed and often with not enough consideration of the individual needs of the prisoner. Records of prisoners' daily interaction were often missing and, most importantly, change in risk levels were not always explained. For example, we saw a case review of a prisoner whose observation levels had reduced from four meaningful conversations a day and three observations per hour to just one observation per hour. No explanation was provided to rationalise these reductions.

3.39 In 2021 to date, there had been 51 occasions where prisoners had been subject to constant supervision arrangements. Although there were no prisoners on constant supervision during our inspection, our review of past ACCT documents identified areas that required improvement. We found that supervising staff did little to encourage purposeful interaction and participation for prisoners subject to constant supervision. The care plans for such prisoners were often crossed out with the assumption that additional support would be halted while they were under constant observation, while in practice they required additional support for being in crisis.

3.40 Comprehensive self-harm data were collated and reviewed in monthly safer prisons meetings, with some evidence of further exploration of trends. Attendance at this key meeting needed improvement. The more complex cases were allocated for discussion at the weekly safer intervention meeting (see paragraph 3.15), but this focused mainly on other safety issues with complex cases merely recorded with no discussion or action planning.

3.41 The Listener scheme had continued to operate throughout the pandemic, but prisoners told us they were not always granted access when requested.There was a significant shortage of Listeners, which the prison was aware of and looking to rectify. The small team spoke highly of the support they received from the Samaritans.

Recommendations

3.42 **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.**

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

Protection of adults at risk (see Glossary of terms)

3.44 The prison's safeguarding policy provided comprehensive guidance on identifying prisoners at risk and subsequent actions to be taken. The policy was not fully embedded; most staff were unclear of its existence and unaware of safeguarding procedures. Staff were aware, however, of the need to raise any concerns about prisoners with the safer custody team or a manager. Due to population pressures, we were not assured that prisoners at risk were always identified. The prison had no links or joint working with the local safeguarding adults board to improve the care and support offered to prisoners at risk. This was a missed opportunity.

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 We observed good staff-prisoner interactions and prisoners we spoke to were largely positive about the staff at Durham.

4.2 The key worker scheme (see glossary of terms) was mostly operating better than we have seen in similar establishments. In our survey, 76% of prisoners said they had a named officer (key worker), against the comparator of 52%. At the time of inspection, prisoners were receiving, on average, a key worker session every two weeks. Prison leaders had good oversight systems for the scheme.

4.3 During the pandemic, prison leaders had replaced key worker sessions with welfare visits, either by telephone or face to face. The keyworker scheme had been restarted but the majority of the sessions we reviewed were superficial in nature. (see paragraph 6.18).

4.4 Prison leaders had developed specialist key worker roles for young adults and veterans, which was positive. Some foreign national key worker sessions were poor as interpreting services were not used.

4.5 With progress in the prison regime, more prisoners were now unlocked during key times. Staff were positioned effectively on residential units to monitor prisoners and we observed some effective challenging of low-level poor behaviour.

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 The prison was overcrowded, with over three-quarters of prisoners living in cramped conditions, sharing cells designed for one. Most shared cells did not have an adequately screened toilet or sufficient lockable cabinets. (See key concern and recommendation 1.41.)

4.7 The standard of cells needed improvement; many had insufficient furniture and equipment, and some were also poorly ventilated and could be too warm or cold. Some cells, particularly on A wing, were in a state of disrepair, but that wing was due for refurbishment. There was also a rolling programme of window refurbishments and an internal programme of prisoner-led refurbishment of cells. (See key concern and recommendation 1.41.)

4.8 Showers varied across the prison, but most had mould and poor ventilation. Many lacked sufficient privacy and passing staff and prisoners could see into them. However, the showers on D wing were of a better standard. In our survey only 55% of prisoners said they could shower daily (compared with 90% at the last inspection), and A and E wings only offered a shower every other day, which was poor.

D wing showers (left) and A wing showers (right).

4.9 There had been improvements to the cleanliness of communal areas. In our survey, 74% of prisoners said areas were clean, compared with 57% at our last inspection. Prison leaders had introduced initiatives to improve standards during the pandemic, including specific 'COVID' cleaners for each wing in addition to wing workers. Prison leaders regularly walked around the establishment to set and improve standards and this had led to good levels of cleanliness in communal and outside areas.

A wing landing

4.10 Prison leaders had allowed all prisoners to wear their own clothes from spring 2021 and had permitted clothing to be brought in during the pandemic. Each wing had industrial-sized washers and dryers with at least weekly access for prisoners to launder their clothes. They also had good access to fresh bedding and cleaning materials. In our survey, prisoners were negative about access to their stored property, but we saw no backlog of property waiting to be distributed.

4.11 Managers did not routinely monitor the answering of cell bells, apart from some limited spot checks that showed the longest wait of 17 minutes for a cell bell to be answered.

Recommendation

4.12 **Emergency cell bells should be answered within five minutes.**

Residential services

4.13 Catering arrangements were adequate. Prisoners' perception of food had improved; in our survey, 39% said the food was good compared with 26% at our last inspection. Prisoners we spoke to complained that they did not get enough to eat. Prison leaders needed to do more to make sure prisoners were getting a sufficient daily calorie intake. There

had been no formal surveys to understand prisoners' views on the food, although the catering managers did respond to issues raised.

4.14 Hot meals were available at both main meals, which were served at appropriate times. In contrast, breakfast, consisting of a small packet of cereal and carton of milk, continued to be issued with the evening meal. Staff did not adequately supervise the serveries, which were not cleaned after evening meals.

4.15 In our survey, only 31% of black and minority ethnic prisoners, compared with 61% of white prisoners, said that the shop sold the things that they needed. Prisoner consultation had led to some revision of the items on sale. New arrivals did not have prompt access to the shop and could wait up to two weeks to receive their first order (see paragraph 3.10). This put them at risk of getting into debt with other prisoners and being bullied. The prison had failed to take adequate action on our two previous recommendations on this matter.

4.16 The prison had introduced an option to buy vapes and a 'goodie' pack midweek, which prisoners valued.

Recommendation

4.17 **Prisoners should be able to buy items from the shop within 24 hours of arrival.** (Repeated recommendation 2.16)

Prisoner consultation, applications and redress

4.18 The number of complaints had reduced by a quarter since our last inspection and was low compared with similar prisons. On average, the prison received just under 100 complaints a month. Prisoners had good access to making complaints with ample complaint forms on each wing.

4.19 Oversight of complaints required improvement. In the last year, almost a fifth had received a late response. Investigations into complaints did not always address the issues raised, particularly when they were about staff. The quality assurance system was weak and lacked detail.

4.20 Prisoners made good use of the electronic kiosk applications system; on a standard week, over 2,000 applications were received. The system only allowed prisoners to submit one application to one department at a time and they could not submit further applications until that had been dealt with, which was a source of frustration for them. This impacted on all aspects of life and made it impossible for remand prisoners to receive their full entitlement of visits. There were 366 applications overdue a response at the time of our inspection. There was no analysis or formal scrutiny of the application system.

4.21 The prison had maintained weekly consultation meetings with prisoners from all wings through the pandemic and was responsive to their concerns, for example, the meetings now invited staff from different departments, such as health and dentistry. There was no formal strategy or mechanism to share information from the meetings with the wider prison population.

4.22 Prison leaders had made improvement to the legal services provision at Durham. There was now a bail officer, which enabled prisoners on remand to gain advice and support in making bail applications. The prison had introduced a new scheme for solicitors to send in legal mail, which aimed to prevent contraband and to reduce mail being opened under suspicion.

Recommendations

4.23 **The application system should allow prisoners to access services as required and not wait unnecessarily.**

4.24 **Responses to complaints should be returned to prisoners on time and there should be a robust system to quality assure complaints against staff.**

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

4.25 Work on equality and diversity was hampered as the prison did not have a complete picture of prisoners with protected characteristics. Data provided to us during the inspection was often delayed, incomplete or incorrect. (See key concern and recommendation 1.42.)

4.26 The prison's comprehensive vulnerabilities screening during reception (see paragraph 3.3) included detailed and useful data on prisoners, such as sexual orientation, but the prison was unable to extract this from individual records to produce an overall picture. Similarly, data on protected characteristics was not reconciled from other sources across the prison, such as health care (disability), education (learning difficulties and disability needs, LDD) and the library (literacy data from the Turning Pages reading programme). This limited the ability of the prison to meet the needs of individuals and groups with protected characteristics.

4.27 The recently appointed head of safer prisons was the senior management lead for equality work, supported by the safer prisons team. One of the team had been designated as the equality officer, although he spent about 60% of his time on safer prisons work.

4.28 Equality work was coordinated at the diversity and inclusion action team (DIAT) meeting every two months. Attendance at this meeting had improved and had recently involved almost every department in

the prison, as well as a prisoner representative. The effectiveness of this forum was undermined by limited analysis of data and a lack of updates on progress by some senior managers with lead responsibility for protected characteristics The prison had yet to develop regular links with community groups to support this forum.

4.29 Senior manager leads for each protected characteristic were expected to arrange forums or other consultation with these groups, but this had not yet resumed apart from a few recent exceptions. Prisoner equality peer representatives had been appointed for each unit and had been given workbooks to complete to help them in their role.

4.30 There had been 34 discrimination incident report forms (DIRFs) submitted during 2021, including 14 from officers challenging discriminatory behaviour by prisoners. The responses to the remaining 20 submitted by prisoners were generally polite, although some did not fully explore all the issues raised and none made it clear whether the complaint was upheld. The deputy governor reviewed every DIRF. DIRFs were not readily available on all the wings and many prisoners we spoke to were not aware of how to report discrimination, including some who had been at Durham for over a year.

Recommendation

4.31 **Prisoners should have free access to discrimination incident report forms (DIRFs) and an independent method of checking responses should be introduced.** (Repeated recommendation 2.31)

Protected characteristics

4.32 The proportion of black and minority ethnic prisoners had increased since the previous inspection to around 11%. There was still no consultation with this group. Over 60% of the DIRFs submitted in 2021 referred to racism in the complaint. The black and minority ethnic prisoners we spoke to had a widely held view that the many cleaners and painters employed on the wings were almost exclusively white, but the prison was unable to produce the data to understand if these perceptions were accurate and take action if needed.

4.33 The prison was not able to provide an accurate list of prisoners from a Gypsy, Roma or Traveller background. We spoke to some of these prisoners who said that, other than being able to speak to the chaplaincy, there was no specific support or consultation for them.

4.34 At the time of the inspection there were 129 foreign national prisoners (13.2%); the largest groups were Albanian (45) and Vietnamese (29). Regular Home Office surgeries had continued, and it was positive that the prison had recently appointed an officer whose role was to support foreign national prisoners. The prison was not able to provide details of how many prisoners needed translation services, but we spoke to many prisoners with very poor English. In one case, a Vietnamese prisoner was at the prison for over a month before staff became aware through another prisoner that he did not have a phone PIN to make

contact with his family. We saw examples of key work sessions that should have been conducted with an interpreter, such as this record of a session with a Vietnamese prisoner:

> *Went and tried to speak to [prisoner], the language barrier is a big issue but felt like he could understand a few things, asked if he was ok and he stuck up his thumb. Asked/Signed if everything was ok on the wing, again he stuck up his thumb. From what I gather everything is ok at the minute for [prisoner].*

4.35 We surveyed 72 prisoners who stated that they had a disability, the majority of whom also said they had mental health problems. In our survey, only 51% of prisoners with a disability, compared with 77% of those without, said staff treated them with respect. DIAT minutes showed that the prison had been seeking information on disability from health care to improve the accuracy of its data, but had not extended this to information held by education in relation to LDD. Many of the prisoners with disabilities were located on F wing, although it had only eight ground-level cells, and we saw examples of prisoners with very reduced mobility (some of whom had a personal emergency evacuation plan, PEEP) located on upper floors. One prisoner on the first floor had to have his meals brought up to him from the servery.

4.36 F wing also housed many of the prison's older population. During the inspection, there was an over-50s meeting in the chapel. This was the first such meeting of the year and provided a much-welcomed opportunity for older prisoners to spend association time together and engage in activities such as bingo. All the prisoners at this meeting were very positive about how staff treated them.

4.37 The prison had recently developed a strategy to support younger prisoners. This included training a cohort of key workers to identify prisoners who could benefit from maturity screening (see Glossary) and working with prison offender managers (POMs) to deliver the Choices and Changes work pack, aimed at developing maturity in young adult prisoners. Given the turnover in population, it was likely that prisoners would transfer before completing this course and no prisoners had yet started this at Durham.

4.38 In our survey, 11 prisoners stated that they were gay or bisexual. The prison was unable to provide an accurate list of prisoners and their sexual orientation.

Recommendations

4.39 **The prison should provide appropriate support for prisoners who struggle to communicate in English.**

4.40 **Prisoners with limited mobility should be located in accommodation that does not limit their access to services.**

Faith and religion

4.41 Corporate worship had resumed and, in our survey, many more prisoners than at similar prisons we have inspected recently (59% against 37%) said they could attend religious services if they wanted. Prisoners could also attend faith-based study classes.

The chapel

4.42 The chaplaincy had continued to provide face-to-face support to prisoners, meeting all new arrivals and all discharges. Chaplains were available for most faiths, either as part of the onsite team or as sessional or volunteers. One of the volunteer chaplains had been involved for many years with outreach work to support people in the area who were street homeless. He knew many of the individuals who repeatedly returned to custody and they attended his faith-based classes designed to provide 'hopefulness for change'.

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.

4.43 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 issued 'requirement to improve' notices following the inspection (see Appendix III).

Strategy, clinical governance and partnerships

4.44 Spectrum Community Health CIC was the prime provider of health care, including clinical substance misuse services. Psychosocial drug and alcohol services were subcontracted to Humankind and mental health care was subcontracted to Tees, Esk and Wear Valleys NHS Foundation Trust. Partnership board, contract meetings and strategic engagement with NHS England and NHS Improvement had continued throughout the pandemic. The local delivery board met monthly, which ensured oversight and governance of health services.

4.45 There had been three significant COVID-19 outbreaks, including one in January 2021 that affected 600 prisoners. We were advised that all had been well managed with outbreak control team meetings and mass COVID-19 testing. Public Health England said that prison and health care staff had worked well together to implement COVID-19 vaccination programmes.

4.46 The head of health care provided a clear vision to staff, but her regular involvement in essential clinical delivery and the lack of a deputy manager had a detrimental impact on oversight and strategic management. At the time of our visit, the GP service was provided by locums, supported by advanced nurse practitioners, but lacked consistent onsite GP supervision and management. Recruitment was ongoing but there were staff shortages in all areas, which meant many aspects of routine care were delayed, causing frustration for many patients. (See key concern and recommendation 1.43.)

4.47 Compliance with mandatory training was reasonable. Most staff felt supported by their line managers and clinical supervision had been ongoing.

4.48 Patient feedback was obtained in a range of ways. ABL Health conducted interviews and surveys with patients, sharing the results with the provider. Patients could complete a ‘You talk, we listen, we do’ feedback card. Health care leads attended the prison-led prisoner forum to address concerns raised about health services.

4.49 The health care reception room lacked privacy, with patients and staff clearly visible to others, which was unacceptable. A room on the induction wing, used by clinical staff to review patients with substance misuse issues, contained a urinal that also had no privacy (see also paragraph 4.82). Neither room met infection prevention and control standards, nor did they provide the necessary confidential or dignified environment.

4.50 All staff maintained the electronic medical record, SystmOne. They had been trained in record-keeping and the standard of entries was reasonable. Many care plans lacked evidence of patient involvement and were written in language not easily understood by prisoners with limited reading skills.

4.51 Emergency resuscitation equipment was in good condition and during the pandemic staff completed mandatory immediate online life support training provided by a local hospital. An ambulance was automatically called when an emergency call was made.

4.52 Patients could submit confidential complaints, which were replied to promptly. Replies were respectful and addressed the key concerns raised.

Recommendation

4.53 **The reception and induction wing clinic rooms should be refurbished to meet required standards for patient privacy, dignity, and infection prevention and control.**

Promoting health and well-being

4.54 Spectrum Community CIC had a regional seven-prison health promotion strategy, but this had not been adopted into a form that focused on the needs of patients in HMP Durham. Health promotion material was visible across the prison and addressed a range of issues, including COVID-19 vaccination, chlamydia screening and testicular cancer. Posters and information were available in a range of languages. Health services had access to telephone interpreting services for appointments.

4.55 Some screening programmes had been affected by the pandemic, but retinal and abdominal aortic aneurysm screening had recommenced, and patients were referred appropriately. NHS age-related health checks were not offered consistently. Bowel screening had recommenced in April 2021.

4.56 All new arrivals were offered screening for hepatitis B and C at the initial or secondary health care reception appointment, and hepatitis C positive patients were referred to specialist services. Patients who moved on to other local prisons were tracked and followed up by the specialist nurses.

4.57 Health care and prison staff worked together to deliver COVID-19 vaccinations across the prison. Prisoners who declined the vaccination were encouraged to receive it before release; the invitation to be immunised remained open and health care staff raised it at every contact.

Primary care and inpatient services

4.58 New prisoners regularly arrived late into the prison (see paragraph 3.3) and a significant number had not received their initial health screen before they were moved to the wing. (See key concern and recommendation 1.44.) There was very limited risk assessment of the patients who had not been seen, comprising a conversation through the cell hatch on the first night wing. Not all new arrivals were checked on during the first night. We raised this during the inspection and steps were taken to address this area of risk.

4.59 New arrivals were located on the induction units where they had a period of isolation with two voluntary COVID-19 tests. They were asked about their COVID-19 vaccination status and put on the waiting list if vaccination was required.

4.60 The staff team had been affected by shortages, but core services had been prioritised, such as medicines administration, electrocardiogram (ECG) investigations, blood tests and wound dressings. Checks were made on patients with COVID-19 symptoms or who were self-isolating.

4.61 Patients requested a health appointment via the electronic kiosk (see paragraph 4.20). There was no clinical triage of applications and many patients were allocated to the GP waiting list inappropriately. There was limited oversight of waiting lists and, if a patient's needs became more urgent, there was no robust system to make sure that this was addressed. Staff had started to take a more active approach when patients did not attend an appointment by contacting them on their in-cell phone or speaking to wing staff.

4.62 In our survey, just 13% of prisoners said it was easy to see the GP. At the time of our inspection, 264 patients were on the GP waiting list with some waiting more than eight weeks. There had been no clinical prioritisation or triage of these patients. In the clinical records we surveyed, there was an absence of risk management and review of patients' conditions and medications, despite evidence of worsening symptoms for some patients; we raised this during the visit. There were long waits to see the optician and podiatrist. (See key concern and recommendation 1.43.)

4.63 There was not enough GP capacity to see patients, manage administrative tasks, process prescriptions and review pathology results. Patients with long-term conditions did not always receive person-centred, holistic care and had not always received timely reviews of their condition. A recently appointed lead nurse for patients with complex care needs was starting to address this. (See key concern and recommendation 1.43.)

4.64 The inpatient unit was very clean and provided a caring environment for patients requiring ongoing care. Staff knew the patients well and patients told us they felt cared for by the staff.

Social care

4.65 Social care arrangements were informed by a memorandum of understanding between the local authority and the prison, which had been recently reviewed and was undergoing sign-off from the various signatories. Spectrum delivered the domiciliary care, although nobody was currently receiving social care support.

4.66 Spectrum made referrals for social care assessments to the local authority, although the prison could also make referrals directly. The local authority had provided 'trusted assessor' training to some

Spectrum staff to enable the rapid provision of care should it be required.

4.67 Plans were being developed to establish a store of mobility equipment in the prison to reduce the time for prisoners to be provided with any aids required.

Mental health care

4.68 Tees, Esk and Wear Valleys NHS Foundation Trust provided secondary care mental health services and subcontracted primary care services to Rethink. Mental health services operated seven days a week. A stepped model of care was used to manage the level of support provided to patients with mild-to-moderate and more complex needs. Recent changes to the service model had seen the creation of urgent and planned care pathways, although this was still being embedded. Ongoing staffing shortages, together with the impact of the pandemic, meant the provision of planned care did not always meet the needs of patients. Urgent care, triaging of new referrals and attendance at assessment, care in custody and teamwork (ACCT) case management reviews were prioritised.

4.69 The team comprised skilled and experienced mental health practitioners and there was regular psychiatric input. The roles of social worker and speech and language therapist were a valued resource. Staff told us they received regular supervision and felt well supported. Training compliance was within the required Trust target. The team manager position remained vacant, although the locality manager provided good oversight and support to the team.

4.70 There was a high level of demand and referrals were received from a variety of sources, including self-referral. These were triaged daily by the urgent care staff and any patients deemed to have urgent needs were assessed within four hours. Routine referrals were taking up to three weeks to assess in secondary care and up to four weeks in primary care, which was too long.

4.71 A dedicated team provided support to people with more severe mental health needs on the integrated support unit (I wing). Staffing on I wing was protected, although staff shortages had also affected the team. The unit benefited from a regular team of prison officers, which ensured consistency. The physical environment was limited, but had been enhanced with information displays and patient artwork. Patients were involved in planning activities and we observed a group taking part in an inclusive sensory activity. Care planning was robust and patients were regularly reviewed during their stay. The regime on the unit had recently been affected by the location of new arrivals there due to a lack of capacity elsewhere (see paragraph 3.8).

4.72 At the time of the inspection, the teams were supporting 96 patients with more complex needs, which included 13 under the care programme approach (CPA). A further 30 patients were being supported by the primary care team. The team visited the segregation

unit regularly and attended ACCT case management reviews for individuals on their caseload.

4.73 The physical care pathway for patients taking mental health medicines was fragmented and physical health checks were not always carried out at the required frequency.

4.74 Most care had continued to be delivered face to face during the pandemic, although this had been curtailed by the COVID-19 restrictions. Due to national guidance, groups were still not being offered across the wider prison, although work was in progress to resume these. The ISU were still offering and delivering small bespoke therapy groups in line with guidance. As there was only one external phone available to all mental health staff, the mental health team had requested further phone lines be installed. The one in-cell telephone had been effectively used each day throughout the COVID-19 pandemic to contact and engage with patients. In-cell distraction packs were provided.

4.75 The clinical records we sampled were of a good standard, but follow-up actions were not always completed. Care plans were of a variable standard, with some not being personalised and care plans absent in others.

4.76 Tees, Esk and Wear Valleys had created a package of mental health awareness training for officers, but due to operational pressures prison staff had been unable to take up the training.

4.77 Since November 2020, there had been 10 transfers to low and medium secure units under the Mental Health Act. Only two had been within the national guidelines, with several patients waiting for between three and five months for an available bed. A further three patients were awaiting transfer. Processes to transfer patients had been affected by COVID-19 outbreaks within the prison and secure bed environments. This situation had not improved since our inspection in 2016.

Recommendations

4.78 **Patients prescribed medicines for their mental health should receive the required physical health checks in line with evidence-based practice.**

4.79 **Patients sectioned under the Mental Health Act should be transferred within the transfer timescale guidelines.** (Repeated recommendation 2.86)

Substance misuse treatment

4.80 Spectrum CIC provided clinical substance misuse services and Humankind delivered psychosocial services. Both services were an integral part of the prison's wider drug strategy and regular meetings took place. Despite some gaps in clinical staffing due to recruitment difficulties, prisoners were receiving good care.

4.81 All new arrivals were screened for alcohol and/or drug withdrawal, but persistent late arrivals to the prison meant that some were unable to see a prescriber before they were located to their cell. This risk was offset by health staff having access to a remote prescriber out of hours and the records we looked at demonstrated that this was used effectively.

4.82 Prescribers provided flexible prescribing in line with individual need and national guidance. At the time of the inspection, 195 patients were receiving opiate substitution treatment and those we spoke to were happy with their care. Patients being assessed in the clinical room on the first night centre were required to provide a urine sample for drug screening using an unscreened urinal in the room, which was inappropriate and undignified (see paragraph 4.49 and recommendation 4.53).

4.83 Clinical reviews took place jointly with psychosocial services and services were focused on addressing a backlog of 32 patients who were overdue their 13-week review.

4.84 The methadone administration we observed continued to have queues unsupervised by custody staff, which created unnecessary risks, and administration was not confidential on D and E wings.

4.85 Psychosocial services had continued to deliver individual and wing-based work throughout the pandemic and had recently reinstated valuable groupwork. There were advanced plans to reintroduce mutual aid, such as Alcoholics Anonymous and Narcotics Anonymous, to the prison and to re-establish peer mentors.

4.86 There were 348 patients engaged with psychosocial interventions at the time of the inspection. The recovery-based care plans we looked at were patient-centred and regularly reviewed with the patient. All custody officers we spoke to valued the role of substance misuse services and told us they would refer prisoners to the service who they suspected were under the influence of drugs or drink.

4.87 Psychosocial practitioners saw prisoners in segregation suspected of having secreted items every day to encourage engagement with their service and to provide education on the potential risks associated with secreted items.

4.88 Patients leaving the prison were offered harm minimisation advice and naloxone (treatment to reverse the effects of opiate overdose) training and supplies, as necessary. When patients transferred to another prison or were released into the community, services liaised to make sure there was effective discharge planning.

Recommendation

4.89 **Prison officers should consistently monitor and manage medication administration queues to reduce the opportunities for**

bullying and diversion and maintain patient confidentiality at the hatch. (Repeated recommendation 2.108)

Medicines optimisation and pharmacy services

4.90 Medicines were managed by Spectrum pharmacy staff and two pharmacists provided strong leadership. Additional pharmacy technicians had been recruited and further expansion of the team was being considered. A regular pharmacy clinic took place, which was positive.

4.91 Between July and October 2021, 96-98% of patients had a risk assessment for in-possession medicines. A sample of records we reviewed showed that each patient had an up-to-date risk assessment. There had been improvements in the reconciliation of patients' medicines within 72 hours of their arrival, from 38% in August 2021 to 95% in October.

4.92 Staff did not always complete records on the administration of medicines and so it was not possible to determine if those medicines had been given. There was limited follow-up of patients who did not attend to collect their medicines, especially where they had missed consecutive doses, which was of concern. Prisoners were not able to use the electronic kiosk to order medicines on a repeat prescription and request a health care appointment at the same time (see paragraph 4.20). This issue was being addressed by the prison. (See also recommendation 4.23.)

4.93 The prescribing of medicines liable to abuse was monitored monthly and discussed during medicines management meetings. The prescribing of mirtazapine (an antidepressant) was high and this had been identified by Spectrum as an issue. Officer supervision at the medicine administration hatches was inconsistent, which increased the risk of diversion. During our inspection a medicines administration hatch was closed due to the absence of officer supervision.

4.94 Medicines were administered three times a day, with some provision for night-time doses as well. We observed competent medicine administration in treatment rooms, which included the administration of methadone. Staff were polite and respectful, while ensuring that they checked patients' identity before administering their medicines.

4.95 Medicines needing cold storage were kept in suitable refrigerators and temperatures were within the required range. However, fridge and room temperatures were not always checked daily so there was a risk that medicines may have been exposed to temperatures outside the acceptable range.

4.96 A good range of medicines were available in the emergency stock cupboard and staff knew how to access this.

Recommendation

4.97 **Patients should have access to their medicines at the prescribed times and staff should follow up any who do not collect their medicines.**

Dental services and oral health

4.98 Burgess and Hyder Dental Group was commissioned to provide dental services. At the time of the inspection, the waiting list for an appointment was 30 weeks and had 187 patients. The dental team were frustrated that they were unable to carry out aerosol-generating procedures (AGPs, see Glossary) due to ventilation issues in the dental suite and this was further affecting the long waiting list.

4.99 Patients requiring urgent treatment were seen within 48 hours and the clinical records we looked at confirmed that appropriate antibiotics and pain relief were prescribed. Oral health promotion was delivered during appointments.

4.100 The dental clinic met infection control standards. Staff completed decontamination audits and equipment checks to make sure safety standards were met and adhered to.

Recommendation

4.101 **The dental team should be able to deliver aerosol-generating procedures to allow patients to receive the full range of NHS dental treatments.**

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 Prison leaders had opened up the regime from 8 November 2021 and had started a programme that increased prisoners' time out of cell. This move had already increased the number in employment, but, at 20 months after the start of the pandemic restrictions, had been slow to resume.

5.2 During our inspection, time out of cell varied greatly. A fifth of prisoners were newly arrived and therefore subject to reverse cohorting, which meant they received only half an hour in the open air every day and 45 minutes for domestic activity every other day, which was poor. Unemployed prisoners, who made up almost half the population, received an hour a day in the open air and a 45-minute domestic period for showers and to use information kiosks. Those employed full or part time, almost a third of the population, had between four and 6.5 hours out of their cell on weekdays. In our spot check, we found 56% of prisoners locked behind their doors and 25% at work or in out-of-cell education (the rest were on domestic duties or having time in the open air). Prisoners in full-time employment and working off the wing were not offered time in the open air on weekdays, which was unsatisfactory. The exercise yards were clean and tidy; the main yard was pleasant with greenery and exercise equipment.

Main exercise yard

5.3 The library service was reasonably good. Prisoners had been able to visit the library since September 2021 and the capacity for each session had recently increased. Staff from Durham County Council had returned to the prison and in addition to the stock held could access 750,000 items via catalogue. The prison had decided to maintain the pick-and-collect service introduced during the pandemic, as library staff believed this was used by prisoners who would not otherwise attended the library. There were books and magazines for some prisoners with protected characteristics, such as a range of LGBTQ books.

LGBT books in the library.

5.4 There were some books in foreign languages and the library had produced printouts of this stock that could be sent to prisoners on request. There were more books in Albanian and Vietnamese, which represented the foreign national prisoner profile. Library staff no longer took part in the induction process and were not routinely notified when foreign national prisoners arrived so that they could order appropriate stock or encourage them to use the library. The library held legal texts and printed items for prisoners on request, such as sentencing guidelines, which were popular among remand prisoners. However, the kiosk system did not allow messages to be sent to and from the library, which slowed communication, and some prisoners had been transferred or released before their request was dealt with (see paragraph 4.20 and recommendation 4.23).

5.5 The library supported literacy initiatives and in the previous three months over 130 prisoners had completed the Reading Ahead literacy scheme. Prisoners also attended the library to complete the Turning Pages programme with a Shannon Trust mentor (see Glossary).

5.6 Prisoners benefited from two gymnasiums with a good range of equipment. Both had been used during the summer to offer PE sessions, although social distancing measures had limited the number of places. The capacity of the main gym had recently been increased to 25 and all equipment was once again available. The published

timetable indicated that most prisoners should get at least two sessions a week, but it had not been adjusted to take account of the recent regime changes, such as more education and work spaces, and sessions were often undersubscribed. The outdoor all-weather pitch was being used as an exercise area for prisoners on the reverse cohort unit. Prisoners were encouraged to participate in competitions, such as a virtual indoor rowing league with other prisons. The previously offered healthy living course remained suspended with no plans for it to resume.

Recommendation

5.7 **All prisoners should be offered daily time in the open air.**

Education, skills and work activities

This part of the report is written by Ofsted inspectors using Ofsted's inspection framework, available at https://www.gov.uk/government/publications/education-inspection-framework.

Ofsted inspects the provision of education, skills and work in custodial establishments using the same inspection framework and methodology it applies to further education and skills provision in the wider community. This covers four areas: quality of education, behaviour and attitudes, personal development and leadership and management. The findings are presented in the order of the learner journey in the establishment. Together with the key concerns and recommendations, provided in the summary section of this report, this constitutes Ofsted's assessment of what the establishment does well and what it needs to do better.

5.8 Ofsted made the following assessments about the education, skills and work provision:

Overall effectiveness: requires improvement.

Quality of education: requires improvement.

Behaviour and attitudes: requires improvement.

Personal development: requires improvement.

Leadership and management: requires improvement.

5.9 Leaders and managers had a clear and appropriate plan for the curriculum in education, skills and work. It provided for the

development of literacy, numeracy, vocational and personal skills. It was suitable preparation for prisoners' progression to regional prisons or for release.

5.10 During the pandemic restrictions, leaders worked hard to sustain the curriculum for prisoners through the provision of well-designed in-cell booklets. As the restrictions eased, they provided face-to-face support on the wings for the prisoners who most needed it. Teachers identified and supported prisoners with poor literacy through individual teaching and helpful oral feedback. However, the return to face-to-face education and vocational training workshops had been slow. Since November 2021, leaders had accelerated this process.

5.11 Given the nature of the prison and the high volume of appointments and court appearances for prisoners, leaders understandably planned for a large proportion of part-time activity places. While enough activity places were provided in the plan, a combination of staff shortages in construction skills and some facilities in barbering that were not ready for use meant that a minority of prisoners were not able to develop their practical skills. The range of activities for vulnerable prisoners was reasonable and included mathematics, English, English for speakers of other languages (ESOL), social enterprise, community projects and tea-packing.

5.12 Education managers had a good understanding of the key strengths and weaknesses in the provision. However, leaders had underestimated the weaknesses in the offer of ESOL. Leaders and managers had improved the processes for assuring quality of provision, but there was insufficient focus on the impact of leaders' actions on prisoners' learning. Consequently, only half the recommendations from the previous inspection had been implemented.

5.13 Leaders had recently re-established the initial advice and guidance and allocation processes. Staff provided prisoners with comprehensive information about their options and choices, and gave them an opportunity to plan their long-term goals. However, during the restrictions, the induction and allocation process had not operated effectively. Consequently, there was a large backlog of prisoners who needed to complete the induction and some were not in activities that met their long-term goals.

5.14 Because most places in education were part time while most jobs on the wing were full time and judged to have additional responsibility, there was a financial incentive for prisoners to aspire to wing work and a disincentive to attend education. There was no inequity in the pay policy for attending education or work. Attendance in education was too low and had not yet returned to the high pre-restriction levels. Prisoners did not have the option to combine work with in-cell learning. (See key concerns and recommendations 1.45.)

5.15 Education managers had introduced a new strategy for supporting learners with additional learning needs. They had trained teachers, trainers and instructors to identify and support learners' needs well.

Prisoners who were assessed with additional needs made good progress. Teachers adapted their teaching, supported prisoners' behaviour better and used additional support in the classroom more effectively. However, there was a backlog of prisoners with additional needs who had yet to benefit from the appropriate support.

5.16 Teachers and tutors planned learning activities across most of education and vocational training well. Topics were planned in a logical way to allow prisoners to build upon and consolidate previously acquired knowledge and skills.

5.17 In creative community projects, social enterprise and horticulture courses, prisoners produced work of good quality and showed the development of new knowledge and skills. For example, in community projects, prisoners learned new software packages to enable them to produce magazine articles on topics such as racism in football. In horticulture, prisoners rapidly gained new knowledge about different types of plant, how to take cuttings and make compost. In social enterprise, teachers taught the fundamental business principles of break-even analysis before embarking on the design and production of Valentine cards. Teachers and instructors were well qualified and had appropriate vocational experience.

5.18 However, in ESOL and the multi-skills course, the quality of education was not good enough. Leaders were rightly concerned that there was not enough provision for ESOL learners. In ESOL, teachers did not plan the curriculum well. They did not use prisoners' starting points as the basis for planning their learning activities or provide enough opportunities for prisoners to practise their speaking and listening skills and use them in prison contexts. As a result, some prisoners found the written language in learning activities too difficult. For many, the context of the learning was not relevant. For example, the teacher expected the group to make a cardboard car from written instructions. Some prisoners did not understand the language; others used their first language to communicate. The teacher did not make clear how this exercise and related vocabulary would help the prisoners to develop the language skills to thrive in the prison. As a result, prisoners did not make good progress.

5.19 Education leaders had developed a well-designed multi-skills course to provide the prisoners with short taster activities in different practical aspects of the construction industry, but due to staff shortages had not opened the practical workshops for this course. Teachers had prepared some useful in-cell packs that developed prisoners' theoretical understanding. Prisoners did not develop their practical skills and were making little progress.

5.20 Within the print, waste management, charity and Ministry of Defence net manufacture workshops prisoners learned new skills and processes. Instructors produced helpful written guides to explain how to complete procedures. Prisoners recorded their progress in training portfolios and instructors provided certificates to mark their achievement. With the support of peripatetic tutors, prisoners in work

made good progress in English and mathematics. During the restrictions, a small number of prisoners had been entered for examinations in English and mathematics and nearly all had achieved.

5.21 In wing cleaning work, prisoners were too often not engaged in activities that improved their skills. They did not record their skill development. Leaders were aware of this and had recently appointed two employment coaches, but it was too early to evaluate the impact of this.

5.22 Prisoners who attended education, skills and work worked well in a calm and respectful environment. Most developed the positive attitudes they needed for work and future employment. Prisoners adhered to safe working practices, as expected in the workplace. Staff quickly challenged any inappropriate behaviour. However, prisoners were often late to activities, and in waste management they took too long to start work.

5.23 In both education and industries, managers provided a year-round programme of enrichment events. For example, prisoners celebrated diversity through activities such as a Gypsy and Traveller week, and 'British values' through events around the Remembrance weekend.

5.24 The 'Think family' course provided valuable personal development for the prisoners who attended. Prisoners learned about positive relationships, teamwork and healthy living. Teachers taught the course with commitment and passion, and it was valued and well attended by prisoners. Throughout education, skills and work, prisoners took the opportunity to take on more responsible roles and to support other prisoners, although the formal mentoring programme had not yet been re-established.

5.25 The recently reintroduced, pre-release service was helpful. Prisoners had access to the 'virtual campus' (internet access to community education, training and employment opportunities) to create a curriculum vitae and conduct job searches. Staff had begun to provide good support for prisoners seeking employment after release. They had established good links to agencies offering employment and provided a range of workshops to develop prisoners' skills in applying for jobs. Leaders had effective links with local prisons in Tees and Wear to aid prisoner transfer. When prisoners arrived at the new prison, the outcomes from their initial assessment and long-term targets were transferred promptly, so they could make a swift and appropriate start in education, skills and work.

Recommendation

5.26 **Leaders should reopen the multi-skills workshops to enable more prisoners to develop their practical skills.**

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

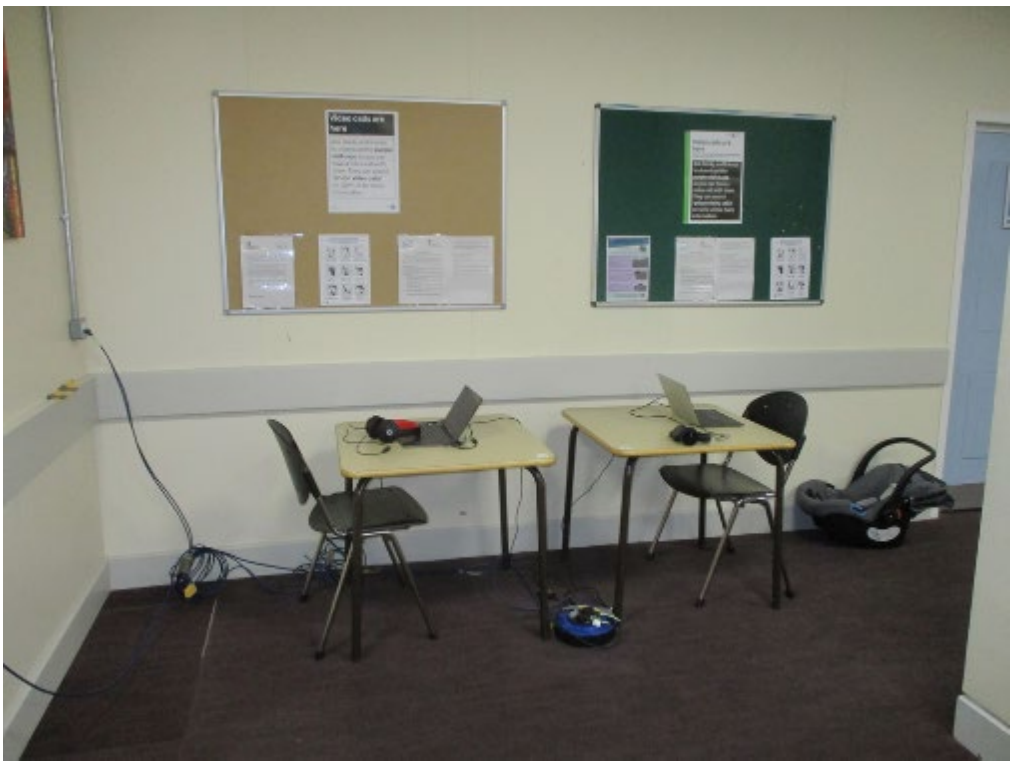
Expected outcomes: The prison supports prisoners' contact with their families and friends. Programmes aimed at developing parenting and relationship skills are facilitated by the prison. Prisoners not receiving visits are supported in other ways to establish or maintain family support.

6.1 The prison had a clear strategy for supporting prisoners to develop and maintain family relationships and worked closely with NEPACS (see Glossary of terms) to deliver this. However, many prisoners told us of their frustration with the visits process.

6.2 Family and friends could no longer contact the prison to request a visit, instead prisoners had to use the wing-based kiosks to apply for a visit, either in person or by a secure video call (see Glossary). Once approved by the booking staff, a text message was sent to the visitor offering a session in the following 48 hours. Visits were available every afternoon and on four mornings including the weekend. The evening visits session had not yet been reintroduced.

6.3 The visits booking process was failing. At the time of the inspection, over 400 applications were waiting to be dealt with and we were told these were being processed two weeks after they had been submitted. Prison data showed that in the previous six months, 60% of applications were rejected. In such instances, the prisoner would have to submit a new application. Many prisoners told us they could often get no more than one visit a month, including those on remand who are entitled to three visits a week. Despite the number of applications, during the inspection some of the sessions had only a handful of visitors. (See key concern and recommendation 1.47.) All the visitors we spoke to said they had been treated well at the prison.

6.4 The café in the visits' hall had reopened, but the children's play area had not. Some of the chairs needed refurbishment. The hall was also used for secure video calls, with some screened tables, although other tables lacked privacy and were drab. Prisoners could apply for one 30-minute video call a month, in place of one of the two-hour social visits they were entitled to.



Drab video calling area and ripped seats in the visits hall

6.5 A new family support structure had been introduced in September 2021 with three family support workers (FSWs). The NEPACS 'early days' FSW was based in the prison and supported prisoners and their families in the first 14 days of custody. She was very visible on the wings and many prisoners spoke highly of her help. Longer term support was then offered from the FSW employed by the prison and

based in the NEPACS visitors' centre. A third FSW was embedded in the substance misuse services team. A family support team meeting coordinated this work.

6.6 The prison FSW had recently implemented an initiative for prisoners to purchase a cuddly toy and record a short voice message to be placed inside for their children to listen to, which was popular among prisoners.

Message in a bear initiative

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.

6.7 Strategic management of offender management required some improvement. The heads of reducing reoffending and offender management were both relatively new in post, and the senior probation officer (SPO) had been seconded to a role outside the prison and their post filled with short-term replacements, which led to a lack of continuity for the department.

6.8 The reducing reoffending policy and action plan were focused on COVID-19 recovery and did not link with offender management. There was no offender management policy or action plan and no up-to-date assessment of prisoner need.

6.9 Almost two-thirds of the population were unsentenced or on remand, and prisoners spent long periods in custody due to backlogs in the courts. The prison provided little to support these prisoners or occupy them while in custody, and their resettlement needs were not assessed or met.

6.10 The monthly reducing reoffending meeting was well attended and included reports from other departments and partner agencies on each of the reducing reoffending pathways. Work on these pathways was not fed into the resettlement plans and so release arrangements were not coordinated and made some provision on release sourced by the prison difficult for the prisoner to attend.

6.11 There was a significant shortfall of administration staff. Considering this, leaders had prioritised work effectively to make sure that essential tasks were completed on time and had minimised the impact on outcomes for prisoners well. Support was also provided by senior leaders who had agreed to increase the overall number of staff in the department and were recruiting for the vacancies and additional positions.

6.12 The group of prison offender managers (POMs), which comprised six probation staff and 8.5 prison staff, were rarely redeployed and allowed to focus on their primary tasks, which has not often been the case at similar prisons we have inspected recently. Caseloads were appropriate, averaging at around 20 cases for probation staff, which were all high risk, and 35 for prison staff, who held medium- and low-risk cases.

6.13 The responsibility to complete initial OASys (offender assessment system) assessments lay with the prison where the prisoner was allocated for transfer, but leaders made sure one was completed for any prisoner who remained in Durham for five or more weeks; this positive move helped shorter term prisoners begin their sentence plans immediately on arrival at their next prison.

6.14 There was no backlog of OASys assessments, with only one outstanding at the time of our inspection. Of the 20 cases we viewed, the quality of most was good with appropriate sentence plan targets and levels of risk suitably identified.

6.15 Risk management plans, which were completed as part of the initial OASys, were of a good standard. We saw evidence of good links with community offender managers (COMs) in the files we sampled with levels of risk accurately identified and suitable actions to address them. Release arrangements for high-risk prisoners were well communicated and managed in conjunction with the interdepartmental risk management team (IDRMT) (see paragraph 6.21).

6.16 There was a lack of management oversight of the OASys process and little quality assurance. Leaders did not routinely check high-risk cases or countersign them to make sure that prisoners who posed the greatest risk were identified or had appropriate sentence plans.

6.17 Contact between POMs and prisoners was also poor. Around half of the cases we viewed had no recorded contact.

6.18 Regular key work sessions took place for most prisoners face to face, which was good, but the majority dealt with welfare issues rather than the prisoner's resettlement or progression needs (see also paragraph 4.3).

6.19 Home detention curfew was well managed and most prisoners who were assessed as eligible left on time. The bail accommodation support service (BASS) found suitable accommodation for most prisoners who needed it quickly, although it was not always in their local area.

Public protection

6.20 Durham received prisoners directly from the courts and so held both remand prisoners and those convicted of offences of every type, including sex offenders. The dedicated public protection team collated critical risk management information on high-risk prisoners from a wide range of agencies and regions proficiently and promptly to make sure risk management was effective.

6.21 Prisoners who were identified as a high or very high risk of serious harm were discussed at the monthly IDRMT meeting. This meeting also made sure that release planning took place for all high-risk prisoners subject to multi-agency public protection arrangements (MAPPA) six months before their release. The meeting was well attended with regular links via telephone conference with COMs. In the meeting we attended, five cases were looked at in depth and good quality release plans put in place. The actions at this IDRMT were hampered, however, by the refusal of the local approved premises to accept a high-risk prisoner despite the recommendations of both the SPO and COM. The only options were to escalate the issue to higher management and refer the prisoner to the local authority for emergency housing on his day of release; this could pose a risk to the public that could be avoided.

6.22 POMs completed reports for MAPPA meetings promptly and to a good standard. The examples and records we viewed were of good quality and very few were submitted late.

6.23 Prisoners subject to child protection measures or who required telephone or mail monitoring were identified quickly and appropriate restrictions put in place. There were 111 prisoners identified for telephone monitoring at the time of the inspection and there was no backlog of calls to be screened, which we rarely see. The IDRMT decided who should be subject to these measures and reviewed them regularly.

Recommendation

6.24 **Oversight of and quality assurance for the sentence management of high-risk prisoners should make sure that their sentence plans are effective and better protect the public.**

Categorisation and transfers

6.25 Once prisoners had been sentenced, they were promptly allocated a security category that reflected their level of risk and sentence length. Most prisoners were transferred to a prison that could provide suitable progression within 10 days of receiving a sentence from the court. Positively, the prison had stopped keeping prisoners at Durham routinely to undertake specific jobs in the prison.

6.26 The prison struggled to move a very small number of prisoners. Some receiving prisons were reluctant to accept them for various reasons, including the nature of the prisoner's offence. This was inappropriate and detrimental to the sentence progression of the prisoners affected.

Interventions

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

6.27 Durham did not offer any accredited programmes to reduce prisoners' risk of reoffending or harm to the public. This was appropriate since one of its main functions was to categorise and move prisoners shortly after sentencing to a prison that could meet these needs.

6.28 Wing managers completed a basic custody screen for every prisoner on arrival, which identified any immediate concerns. This screen triggered a meeting with resettlement staff within five days of arrival for all prisoners. Resettlement staff used this to help with any immediate issues, such as benefits or rent payments for existing accommodation.

6.29 Prisoners who required proof of ID were helped to get a Citizen Card, but support for them to get bank accounts had recently ceased.

6.30 Employment, training and education outcomes were generated through access to the careers advice service and Novus Exits, a part of the education provision, and we saw evidence of job interviews arranged for prisoners. These arrangements were not communicated to the resettlement team or included in the resettlement plan that was shared with COMs and so the job interviews were unlikely to take place.

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.

6.31 The probation service had recently taken back responsibility for release planning from the community rehabilitation companies (CRCs) and the new national providers were not yet in place or embedded. Staff who were previously employed by the CRCs continued to provide a resettlement service.

6.32 Prisoners were seen 12 weeks before release to complete release plans. These were good quality and aimed to resolve financial issues, provide housing, and help with benefits and gaining employment. High-risk prisoners were now the responsibility of the COM, who completed the resettlement plan and made arrangements for housing or approved premises when required.

6.33 There had been 851 releases from custody in the previous six months of which 480 were categorised by the prison as unplanned; these were predominantly immediate discharges from court or prisoners whose sentence finished almost immediately due to the length of time they had been on remand. Most without accommodation of their own were referred to the local authority for housing on the day of release and a high proportion were released with no fixed accommodation, which was poor. Many high-risk prisoners also left custody with no stable accommodation, which made their support and management in the community difficult.

6.34 Of the 371 releases that the prison could plan for in the previous six months, 214 were placed in accommodation, which meant around 43% of sentenced prisoners were released without suitable accommodation. Most successful placings came through the local authorities' emergency housing process on the day of release. This limited the effectiveness of the resettlement plan as the prisoner could be housed anywhere in the north of England depending on where suitable housing was available. (See key concern and recommendation 1.49.)

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: Due to population pressures, prisoners usually arrived into an environment at the prison that was chaotic and busy, and were allocated to wings not equipped for providing an introduction to Durham. Some new arrivals went into cells that were not adequately furnished, missing basic items such as pillows and blankets or with torn or worn-out mattresses. The early days regime was poor and induction did not cover essential information about life at Durham.

Recommendation: All aspects of prisoners' arrival into the establishment should be effective and fit for purpose, including standards of accommodation and the quality of induction and regime.
(To the governor)

7.2 Key concern 1.39: Review of use of force footage was inadequate and in several incidents leaders had missed actions by staff that needed to be addressed. Much of the footage we observed had been recorded inadequately and provided limited scope to observe clearly what had taken place.

Recommendation: Leaders should make sure that all use of force is reasonable, necessary and proportionate.
(To the governor)

7.3 Key concern 1.40: Governance of the segregation unit was weak and we were not assured that segregated prisoners would be kept safe. The justification for segregating prisoners, especially those on at-risk case management or with mental health concerns, was not always documented appropriately and safety screens were not reviewed routinely.

Recommendation: Prisoners should be kept safe at all times while segregated, and their needs should be recognised and given proper attention.
(To the governor)

7.4 Key concern 1.41: The prison was overcrowded, with over three-quarters of prisoners living in cramped conditions, sharing cells designed for one. Most shared cells did not have adequate screening to the toilet or sufficient lockable cabinets. Many cells had insufficient furniture and equipment, and some were in a state of disrepair.

Recommendation A: Prisoners should not live in overcrowded conditions.
(To the governor)

Recommendation B: Cells should be equipped and furnished to a decent standard.
(To the governor)

7.5 Key concern 1.42: The prison did not have a complete picture of prisoners with protected characteristics. Data were incomplete and had not been reconciled with those from various sources across the prison. Analysis of data was rudimentary and mostly limited to ethnicity and age.

Recommendation: Leaders and managers should use data to construct a clear picture of prisoners with protected characteristics in order to meet their needs.
(To the governor)

7.6 Key concern 1.43: Significant staffing shortages had had a detrimental impact on the delivery of primary care, mental health and pharmacy services, with long delays for routine GP appointments and mental health assessment, and the absence of reviews of ongoing treatment and prescribed medicines.

Recommendation: The prison should work with NHS England and NHS Improvement to make sure there are sufficient health care staff to meet the health needs of the population, in line with national guidelines.
(To the governor)

7.7 Key concern 1.44: The late arrival of prisoners into reception meant that not all received a first night reception health care screening. This created the risk that the health needs of new arrivals were left unassessed before they were transferred to their cells.

Recommendation: All new arrivals should receive a first night health care reception screening before they are moved to the induction wing.
(To the governor)

7.8 Key concern 1.45: Prisoners were prioritising full-time work on the wings, where they were not explicitly developing and recording skills, at the expense of education and vocational training.

Recommendation: The delivery of education, work and skills should allow for a combination of face-to-face and in-cell learning to engage more prisoners in purposeful activity, and the activities, allocations and pay policies should be aligned to motivate prisoners to work towards their long-term goals.
(To the governor)

7.9 Key concern 1.46: Prisoners with needs for provision in English for speakers of other languages were not receiving the quality of education they needed and too many were not getting any support at all.

Recommendation: Leaders should assess, meet the need and improve the quality of provision in English for speakers of other languages.
(To the governor)

7.10 Key concern 1.47: The visits booking process was failing. Applications from prisoners to arrange a visit were being processed two weeks after they had been submitted and many prisoners told us they could often get no more than one visit a month, including prisoners on remand who were entitled to three visits a week.

Recommendation: Managers should make sure that prisoners can access the visits they are entitled to.
(To the governor)

7.11 Key concern 1.48: Some remand prisoners spent long periods in custody due to backlogs in the courts. There was little in place to support these prisoners or occupy them while in custody, and their resettlement needs were not assessed or met.

Recommendation: Managers should assess the needs of the remand population to make sure appropriate support is provided while they are in custody and after release.
(To the governor)

7.12 Key concern 1.49: Nearly all prisoners due for unplanned release and 43% of all sentenced prisoners released, including some high-risk prisoners, did not have suitable housing to go to.

Recommendation: Prisoners should have suitable and stable accommodation on their release.
(To the governor)

Recommendations

7.13 Recommendation 3.17: Challenge, support and intervention plans (CSIPs) should be used effectively for perpetrators of violence and contain meaningful targets of which both prisoners and staff who engage with them each day are aware.
(To the governor)

7.14 Recommendation 3.26: Planned use of control and restraint should be recorded clearly on hand-held camera and all footage, including CCTV, should be retained as part of the review process.
(To the governor)

7.15 Recommendation 3.27: Health care professionals should attend all planned incidents of use of force and make sure the prisoner is monitored while under restraint, providing medical advice to the staff when required.
(To the governor)

7.16 Recommendation 3.42: 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.
(To the governor)

7.17 Recommendation 3.43: Constant supervision arrangements should keep at-risk prisoners safe and encourage them to engage with a purposeful regime wherever possible.
(To the governor)

7.18 Recommendation 4.12: Emergency cell bells should be answered within five minutes.
(To the governor)

7.19 Recommendation 4.17: Prisoners should be able to buy items from the shop within 24 hours of arrival. (Repeated recommendation 2.16)
(To the governor)

7.20 Recommendation 4.23: The application system should allow prisoners to access services as required and not wait unnecessarily.
(To the governor)

7.21 Recommendation 4.24: Responses to complaints should be returned to prisoners on time and there should be a robust system to quality assure complaints against staff.
(To the governor)

7.22 Recommendation 4.31: Prisoners should have free access to discrimination incident report forms (DIRFs) and an independent method of checking responses should be introduced. (Repeated recommendation 2.31)
(To the governor)

7.23 Recommendation 4.39: The prison should provide appropriate support for prisoners who struggle to communicate in English.
(To the governor)

7.24 Recommendation 4.40: Prisoners with limited mobility should be located in accommodation that does not limit their access to services.
(To the governor)

7.25 Recommendation 4.53: The reception and induction wing clinic rooms should be refurbished to meet required standards for patient privacy, dignity, and infection prevention and control.
(To the governor)

7.26 Recommendation 4.78: Patients prescribed medicines for their mental health should receive the required physical health checks in line with evidence-based practice.
(To the governor)

7.27 Recommendation 4.79: Patients sectioned under the Mental Health Act should be transferred within the transfer timescale guidelines.
(Repeated recommendation 2.86)
(To the governor)

7.28 Recommendation 4.89: Prison officers should consistently monitor and manage medication administration queues to reduce the opportunities for bullying and diversion and maintain patient confidentiality at the hatch. (Repeated recommendation 2.108)
(To the governor)

7.29 Recommendation 4.97: Patients should have access to their medicines at the prescribed times and staff should follow up any who do not collect their medicines.
(To the governor)

7.30 Recommendation 4.101: The dental team should be able to deliver aerosol-generating procedures to allow patients to receive the full range of NHS dental treatments.
(To the governor)

7.31 Recommendation 5.7: All prisoners should be offered daily time in the open air.
(To the governor)

7.32 Recommendation 5.26: Leaders should reopen the multi-skills workshops to enable more prisoners to develop their practical skills.
(To the governor)

7.33 Recommendation 6.24: Oversight of and quality assurance for the sentence management of high-risk prisoners should make sure that their sentence plans are effective and better protect the public.
(To the governor)

Section 8 Progress on recommendations from the last full inspection

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, many new prisoners arrived with complex issues and problems, but initial risk assessments were inadequate. Improvements had been made to most vulnerable prisoners' experience during their early days at the prison. Too many prisoners felt unsafe. Levels of violence had increased significantly and were high. Safety was undermined by the widespread availability of illicit substances and the prison lacked sophisticated drug detection tools. Much action intended to manage violence had not been embedded or was ineffective. Segregation was managed reasonably well. The large number of self-inflicted deaths and a cluster of suspected drug-related deaths were of great concern. Assessment, care in custody and teamwork (ACCT) case management records for prisoners at risk of suicide or self-harm remained very poor in too many cases and the prison did not pay sufficient attention to the implementation of Prisons and Probation Ombudsman (PPO) recommendations. Outcomes for prisoners were poor against this healthy prison test.

Key recommendations

Reception and first night processes should include a thorough assessment of prisoners' immediate vulnerabilities, needs and risks through a private interview with custodial staff to ensure appropriate support is offered. (S43)

Additional night-time checks should be undertaken for all new arrivals. (S43)
Achieved

Safety should be improved by reducing the supply of illicit drugs. This should include the introduction and use of more sophisticated drug detection equipment. (S44)
Achieved

The management of prisoners at risk of suicide or self-harm should be given a high priority. There should be a comprehensive action plan covering PPO recommendations that is regularly reviewed to ensure they continue to be implemented effectively. ACCTs should be consistently good and ensure that individual prisoners receive appropriate care and support. (S45)
Partially achieved

Recommendations

The induction programme should be clear, concise and relevant, providing all prisoners, including those who have never been in custody, with enough information to be able to access all services and regime activities. (1.10)
Not achieved

The casework approach to managing and changing poor behaviour and assisting vulnerable prisoners through support and intervention plans should be embedded in practice. (1.18)
Not achieved

Data on adjudications should be routinely analysed to identify emerging patterns; trends should be investigated and action taken to address them. (1.22)
Achieved

The governance of and accountability for the use of force, including special accommodation and all interventions should be improved. (1.28)
Not achieved

Prisoners in the segregation unit should have a constructive daily regime and be able to participate in some purposeful activity. (1.35)
Not achieved

Prisoners on an ACCT should only be located in the segregation unit or in special accommodation as a last resort and when there are exceptional circumstances, which should be recorded clearly. (1.49)
Not achieved

The prison should have a coherent strategy to reduce self-harm, informed by the specific characteristics of the population at HMP Durham. It should include a meaningful analysis of data and an action plan. (1.50)
Not achieved

All staff should be trained in safeguarding procedures and be aware of their responsibilities. (1.52)
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in in 2018, prisoners' perceptions of the way staff treated them were mixed and a few negative interactions we witnessed undermined the positive work of many others. Significant overcrowding persisted. Most wings were clean and outside areas were well maintained. Access to some basic provision had improved and was supported by the new kiosks and in-cell phones. The peer worker role was valuable, but safeguards were not in place to ensure the work they did was appropriate. Consultation was too limited. The applications process had improved, but complaints were not addressed effectively. Equality and diversity work remained weak. Health care was good and I wing was excellent. Outcomes for prisoners were reasonably good against this healthy prison test.

Recommendations

Staff's interactions with prisoners should be monitored and feedback should be offered to ensure they respond confidently and immediately to poor behaviour. (2.4)
Achieved

PID workers should be monitored and supervised to ensure they do not undertake work that staff should be doing or have access to personal information about other prisoners. (2.5)
Achieved

Cells should be decorated and equipped to a good standard and provide a decent environment with sufficient space for the prisoners accommodated there. (2.10, repeated recommendation 2.11)
Not achieved

Regular checks should be made to ensure that cell call bells are answered within five minutes. (2.11)
Not achieved

Prisoners should be able to buy items from the shop within 24 hours of arrival. (2.16, repeated recommendation 2.113)
Not achieved (recommendation repeated, 4.17)

Responses to prisoners' complaints should demonstrate sufficient enquiry and address all issues raised. (2.22)
Not achieved

Equality and diversity should be given a high priority and senior staff should actively promote this area of work. (2.29)
Achieved

The needs of individuals from all minority groups should be identified and reliable arrangements introduced to provide the support they require. (2.30)
Not achieved

Prisoners should have free access to DIRFs and an independent method of checking responses should be introduced. (2.31)
Not achieved (recommendation repeated, 4.31)

All staff in contact with prisoners should be familiar with PEEP procedures and aware of the prisoners needing assistance in an emergency. (2.41)
Achieved

Effective governance processes should be in place to ensure good oversight of the whole service and provide clear lines of accountability and responsibility. (2.55)
Achieved

The prison should introduce a regular health service user forum to inform service delivery and development. (2.56)
Partially achieved

A systematic, prison-wide strategy should be established to promote prisoner well-being. (2.60)
Not achieved

All prisoners should receive a secondary health screening within seven days of their arrival at the prison. (2.70)
Partially achieved

All patients with long-term conditions should receive personalised care planning. (2.71)
Not achieved

Hand-washing and laundry facilities should meet the requirements of the inpatient unit. (2.72)
Achieved

Providers should undertake timely assessments and deliver an appropriate range of interventions. (2.84)
Partially achieved

Practitioners should be able to access appropriate safe spaces to provide individual and group activities. (2.85)
Not achieved

Prisoners sectioned under the Mental Health Act should be transferred within the transfer timescale guidelines. (2.86, repeated recommendation 2.101)
Not achieved (recommendation repeated, 4.79)

All operational staff should have regular mental health awareness training. (2.87, repeated recommendation 2.100)
Not achieved

A process should be in place to ensure prison staff promptly refer prisoners considered to be under the influence of illicit substances to DART services. (2.97)
Achieved

Prisoners should have easy access to advice and support from the pharmacy team. (2.106)
Achieved

Prisoners should receive in-possession medication following a consistent recorded risk assessment that is regularly reviewed and underpinned by current joint policy. (2.107, repeated recommendation 2.91)
Achieved

Prison officers should consistently monitor and manage medication administration queues to reduce the opportunities for bullying and diversion and maintain patient confidentiality at the hatch. (2.108, repeated recommendation 2.92)
Not achieved (recommendation repeated, 4.89)

There should be cohesive governance arrangements between the service providers. (2.109)
Achieved

Purposeful activity

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

At the last inspection, in in 2018, a new core day had been introduced during the inspection period. This halved the number of people associating on wings at any one time, giving better access to some amenities. Relatively few men were locked up during the core day. Access to the library and gym was good. Learning and skills provision had been redesigned to meet the needs of a reception prison and was now based on a non-qualification-based framework. Systems for measuring progress had not been embedded and quality assurance arrangements required improvement. Teaching, learning and assessment also required improvement. Behaviour during activities was generally good and attendance had improved in some areas but punctuality remained an area for improvement. Data on prisoners' achievements was not reliable. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Recommendations

Prisoners in the first night and induction unit should have sufficient time out of their cells so they can settle into a normal prison routine. (3.6)
Not achieved

The system for measuring prisoners' progress should be extended across all activities. (3.15)
Achieved

Arrangements for monitoring the targets tutors and instructors set to measure prisoners' progress should be improved to ensure that achievement data are more credible. (3.16)
Achieved

Leaders and managers should have a more evaluative and self-critical approach when they make judgements about the quality of teaching, learning and assessment so that they can address areas requiring improvement more effectively. (3.17)
Not achieved

Learning support staff, tutors and instructors should better identify and record prisoners' starting points and use the information more skilfully to measure their progress. (3.23)
Not achieved

The delivery of teaching, learning and assessment should be better planned to meet prisoners' different needs and varying abilities and to ensure men make good progress. (3.24)
Not achieved

Managers should strengthen tutors' and instructors' understanding of effective strategies to assist prisoners who need additional support. (3.25)
Achieved

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, work to promote contact with children and families remained good and there was an appropriate focus on regular visits. Offender management was too variable and prison officer offender supervisors lacked training in managing high-risk cases. Overall public protection arrangements remained robust but risk management release planning, especially in high-risk cases, was inconsistent. Categorisation decisions could be justified. Individual progression was not always a high enough priority and some prisoners stayed at Durham too long without being able to demonstrate a reduction in their risks. The work of the community rehabilitation companies (CRCs) had improved, but records did not show clearly how many left the prison without sustainable accommodation. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendation

Offender management of prisoners presenting high risk of harm to others should be improved, and should include adequate training for offender supervisors. High risk cases due for release should receive better management oversight from within the prison, and release planning with the community-based offender manager should be consistently good. (S46)
Not achieved
Recommendations

Visits should start on time. (4.6)
Achieved

The visits booking telephone system should be capable of accommodating the number of visitors calling. (4.7)
Not achieved

A full needs analysis should be undertaken and updated regularly to identify the needs of the prison's diverse population. The analysis should inform the development of detailed policies to meet these needs. (4.19)
Not achieved

Offender supervision should be consistent and reflect the level of need presented by prisoners. (4.20, repeated recommendation 4.19)
Not achieved

Quality assurance, professional and casework supervision should be available for all offender supervisors to support professional development and to ensure consistency of service to prisoners. The role of offender supervisors should be clarified and sufficient time allocated to undertake their work. (4.21, repeated recommendation 4.17)
Not achieved

MAPPA management levels should be confirmed with the community-based offender manager at least six months to release. (4.25)
Achieved

The IDRMT should review all high and very high risk of harm cases prior to release to ensure appropriate action and restrictions are in place. (4.26)
Achieved

Prisoners, especially those assessed as presenting a high risk of harm, should be moved to an appropriate prison promptly enough for them to access appropriate offending behaviour interventions. (4.30)
Achieved

Short interventions such as in-cell work or one-to-one modules should be provided to address the offending behaviour of prisoners remaining at Durham for extended periods. (4.37, repeated recommendation 4.46)
Not achieved

Quality assurance of resettlement provision should be developed in conjunction with the Northumbria and Durham Tees Valley community rehabilitation companies to ensure consistency and effectiveness of service provision. Data on the outcomes should be monitored to evaluate the provision. (4.42, repeated recommendation 4.29)

Not 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 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
Angus Jones	Team leader
David Foot	Inspector
Lindsay Jones	Inspector
David Owens	Inspector
Esra Sari	Inspector
Nadia Syed	Inspector
Dionne Walker	Inspector
Donna Ward	Inspector
Elenor Ben-Ari	Researcher
Charlotte Betts	Researcher
Annie Bunce	Researcher
Rahul Jalil	Researcher
Sarah Goodwin	Lead health and social care inspector
Shaun Thompson	Health and social care inspector
Jenna Green	Care Quality Commission inspector
Matthew Tedstone	Care Quality Commission inspector
Steve Hunsley	Ofsted inspector
Cath Jackson	Ofsted inspector
Allan Shaw	Ofsted inspector
Martin Ward	Ofsted inspector
Shelia Willis	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.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

Aerosol generating procedures (AGPs)
Certain medical and patient care activities that can result in the release of airborne particles (aerosols), and a risk of airborne-transmission of infections that are usually only spread by droplet transmission.

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.

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.

Maturity screening
An assessment within OASys that helps predict an individual's potential for reoffending.

NEPACS
Formerly, North East Prisons After Care Society. Charity promoting the rehabilitation of offenders.

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).

Reverse cohort unit (RCU)
Unit where newly arrived prisoners are held in quarantine for between seven and 10 days.

Secure video calls
A system, commissioned by HMPPS, that 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).

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.

Turning Pages
A reading programme created by the Shannon Trust, written specifically for adults (unlike its predecessor Toe by Toe) and delivered by peer mentors.

Appendix III Care Quality Commission Requirement Notice

Care Quality Commission (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

The inspection of health services at HMP Durham was jointly undertaken by the CQC and HMI Prisons under a memorandum of understanding agreement between the agencies (see https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/working-with-partners/). The Care Quality Commission issued 'requirement to improve' notice/s following this inspection.

Requirement Notices

Provider

Spectrum Community Health C.I.C.

Location

HMP Durham

Location ID

1-8566840794

Regulated activities

Treatment of disease, disorder, or injury and Diagnostic and screening procedures.

Action we have told the provider to take

This notice shows the regulations that were not being met. The provider must send CQC a report that says what action it is going to take to meet these regulations.

Regulation 12 (1)(2) (a) (b) (g)

Care and treatment must be provided in a safe way for service users by assessing the risks to the health and safety of service users receiving care or

treatment, doing all that is reasonably practical to mitigate such risks and the proper and safe management of medicines to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met

Staffing shortages across the primary care team had impacted on the provision of routine care. There was a risk that patients with a long term condition would not receive appropriate care or treatment because of delays in reviews of their condition and care plans.

Patients did not have timely access to a routine GP appointment, at the time of the inspection the waiting time was eight weeks. This was due to insufficient GP capacity as well the lack of clinical triage of patient applications or ongoing review of the waiting list.

When newly arrived patients were not able to be seen in reception for a full healthcare screening, not all measures had been taken to ensure that key risks were identified and monitored during patients' first night. The recording and carrying out of first night checks by healthcare staff was inconsistent.

When patients did not attend to collect their medicines, staff did not always follow this up, in particular when patients had not attended for consecutive doses of medication.

Regulation 17 (1)(2) (a) (b) (c) (d)

Systems and processes must be established and operated effectively to ensure compliance with the requirements in this Part. Such systems or processes must enable the registered person to assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity and to assess, monitor and mitigate the risks relating to the health, safety welfare of service users and others.

Furthermore, the registered person must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and such other records as are necessary to be kept in relation to the management of the regulated activity.

How the regulation was not being met

Ongoing staffing challenges meant that the Head of Healthcare was regularly working clinically, which reduced their ability to provide strategic oversight of the service. This was compounded by the lack of a Deputy Head of Healthcare role and the Head of Healthcare carrying additional responsibilities as the transformation lead.

There were 264 patients on the combined GP and ANP waiting list. There was a lack of triage and oversight of this list, meaning there was no assurance that it was accurate or if patients had been correctly assigned to this waiting list.

Records were not always completed, in particular:

- There were gaps in medicines administration records. This meant it was not clear if medicines had been given or not.

Appendix IV 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.

Any enquiries regarding this publication should be sent to us at the address below or: hmiprisons.enquiries@hmiprisons.gsi.gov.uk

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

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