Report on an unannounced inspection of

HMP Winchester

by HM Chief Inspector of Prisons

31 January – 1 February and 7–11 February 2022

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Introduction

Winchester is a small, Victorian, local prison that serves the courts in south and central England. At the time of our inspection it held nearly 500 prisoners in the main category B prison and a small, separate category C facility. Over half of the prisoners were unsentenced.

At our last inspection in 2019, we found a prison struggling with high levels of violence and which was providing prisoners with very little time out of cell. On our return, we were disappointed to find that – despite some limited progress – our healthy prison test scores remained the same. Winchester continued to be one of the most violent prisons in the country.

While there had been impressive work to reduce the risk posed by some of the most violent prisoners, there was no meaningful strategy to understand and address the causes of violence within the main population. Most prisoners were locked in their cells for 22.5 hours a day, and even more at the weekend. The enthusiastic education managers were very frustrated by the prison's inability to get prisoners to classrooms and workshops, both consistently and on time. This made it impossible to plan work programmes because they did not know who, if anyone, was going turn up each day. There was no assessment of the skills of prisoners when they came into the prison, which meant that those who had been employed in the community were not provided with suitable work.

As during our 2019 inspection, men on the category C side of the prison did not have enough to do. We found a group of relatively low-risk prisoners who were bored and frustrated by the lack of activity, while workshops were underused and the gardens were out of bounds. There is huge scope to develop the offer for these prisoners and create a thriving, productive environment which will support sentence progression and provide an incentive to prisoners on the main site.

Despite some improvements to the fabric of Winchester's buildings, such as new showers on some wings, ongoing issues with the water supply meant that fewer prisoners than any prison we have visited were able to have a daily shower. Many of the cells, particularly on the C4 landing, were covered in graffiti or dilapidated, with worn out furniture and lavatories. Leaders had put up posters around the prison showing their aspiration for how cells ought to look, but there was no credible plan for how or when these improvements would be made.

The prison had struggled to recruit and retain enough staff and this problem was directly affecting the day-to-day running of the jail, where at times there were simply not enough officers to ensure even the most basic regime for prisoners. Officers were frequently cross deployed from the gym and the offender management unit which meant access to these services was further reduced. Leaders will need to develop an understanding of why so many officers (in an affluent part of the country with low levels of unemployment) are leaving the prison and put in place some meaningful support to help retain good staff members during their first year of service.

Inspectors were frequently impressed by many of the officers and staff, who showed great skill and dedication in their work, despite the many challenges that they had faced over the last two years. Leaders had managed to keep visits going during the latest lockdown and this was a real achievement, given how frequently the prison was short staffed.

There is no doubt that the pandemic has limited some of the progress at Winchester, but leaders have failed to show enough real, sustained grip. If it is to improve from this disappointing inspection, the prison will need leaders to be active and visible on the wings, and set clear, measurable targets for improvement so that prisoners are safer, kept in decent conditions and given enough to do during the day.

Charlie Taylor
HM Chief Inspector of Prisons
March 2022

About HMP Winchester

Task of the prison/establishment
HMP Winchester is a category B local men's prison with a separate category C unit. The establishment also holds young adults.

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 492
Baseline certified normal capacity: 448
In-use certified normal capacity: 468
Operational capacity: 564

Population of the prison
- 50% of the population are unsentenced, 39% are the resettlement cohort, 8% are the training cohort and 3% are serving an indeterminate sentence.
- 13% are foreign national prisoners.
- 21% of the population are aged 25 years and under.
- Approximately 80 prisoners are released into the community each month.

Prison status (public or private) and key providers
Public

Physical health provider: Practice Plus Group
Mental health provider: Practice Plus Group
Substance misuse treatment provider: Practice Plus Group
Prison education framework provider: Milton Keynes College
Escort contractor: Serco

Prison group/Department
South Central region

Brief history
HMP Winchester was built in 1849 and has a radial design typical of Victorian prisons. The prison covers an area of approximately six acres. In 1908, the health care unit was built, and in 1964 another unit was added as a remand centre for young offenders. The unit, known as West Hill, continued to be used for this function until 1991, when it started housing women prisoners. In 2004, its role changed to a category C resettlement unit.

Short description of residential units
On the local prison site:
A wing – currently closed for refurbishment.
B wing – remand and convicted prisoners.
C wing – detoxification and integrated drug treatment system. Landing C4 was also used for additional first night cells and reverse cohorting (see Glossary) at the time of the inspection.
D wing – remand and convicted vulnerable prisoners. Landing D4 was also used for first night cells and reverse cohorting at the time of the inspection.

On the category C site:
Two units accommodating category C and a small number of category D prisoners, known as West Hill and the Hearn unit, respectively.

Name of governor/director and date in post
James Bourke, September 2018

Leadership changes since the last inspection
None

Prison Group Director
Andy Lattimore

Independent Monitoring Board chair
Rob Heather

Date of last inspection
17 June – 5 July 2019

Section 1 Summary of key findings

1.1 We last inspected Winchester in 2019 and made 29 recommendations, 15 of which were about areas of key concern. The prison fully accepted 19 of the recommendations and partially (or subject to resources) accepted 10. It rejected none of the recommendations.

1.2 Section 8 contains a full list of recommendations made at the last full inspection and the progress against them.

Progress on key concerns and recommendations from the full inspection

1.3 Our last inspection of Winchester 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 five recommendations about key concerns in the area of safety. At this inspection we found that one of those recommendations had been achieved, two had been partially achieved and two had not been achieved.

1.5 We made four recommendations about key concerns in the area of respect. At this inspection, we found that none of these recommendations had been achieved.

1.6 We made five recommendations about key concerns in the area of purposeful activity. At this inspection, we found that none of these recommendations had been achieved.

1.7 We made one recommendation about key concerns in the area of rehabilitation and release planning. At this inspection we found that this recommendation had been achieved.

Outcomes for prisoners

1.8 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).

1.9 At this inspection of Winchester, we found that outcomes for prisoners had stayed the same for all healthy prison tests for both the local and category C sites.

1.10 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 Winchester local healthy prison outcomes 2019 and 2022

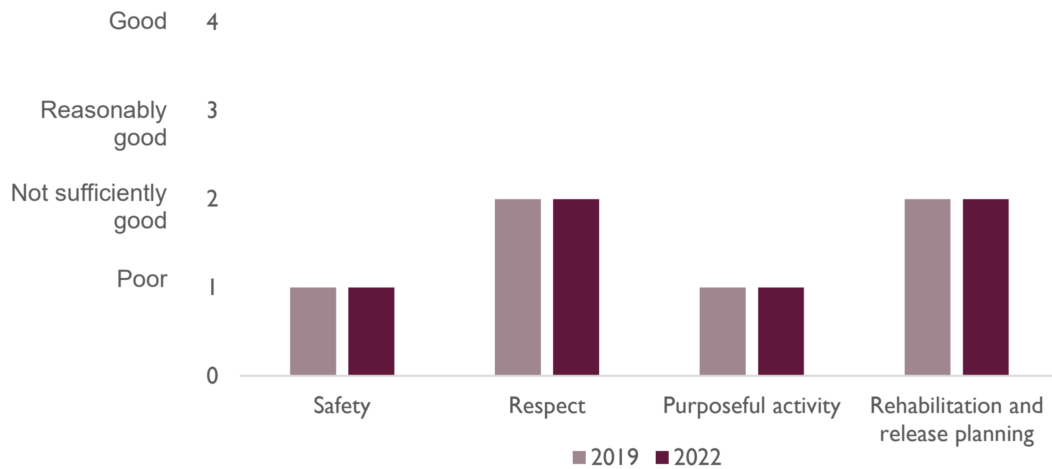
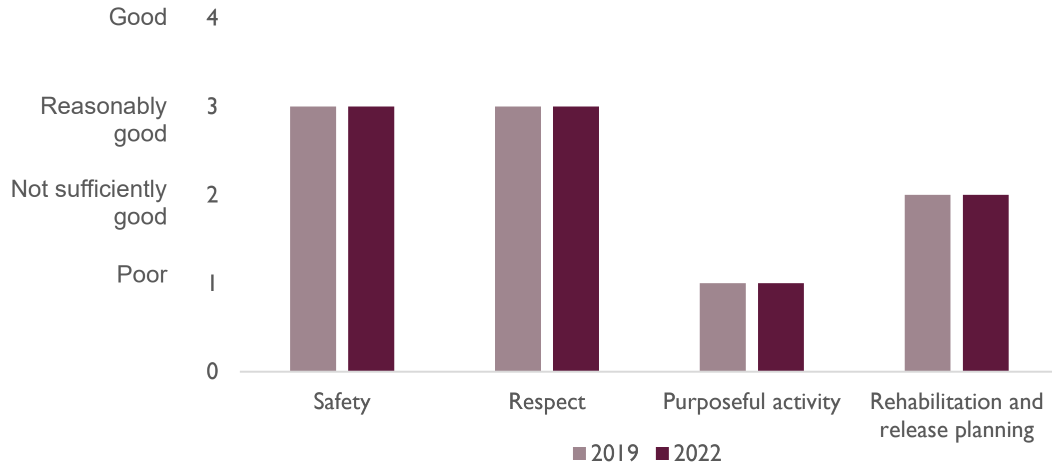


Figure 2: Winchester Category C site healthy establishment outcomes 2019 and 2022



Safety

At the last inspection of Winchester, in 2019, we found that outcomes for prisoners were poor against this healthy prison test for the local site and reasonably good at the category C site.

At this inspection, we found that outcomes for prisoners remained poor on the local site and reasonably good at the category C site.

1.11 In our survey for both sites, prisoners reported more negatively than in similar prisons across several aspects of early days processes. Improvements had been made to initial safety screening to identify risk, but accommodation for prisoners in their early days was poor, and not all prisoners received important aspects of induction.

1.12 The overall numbers of assaults on staff and prisoners were higher than in similar prisons. Although assaults on staff were reducing, prisoner-on-prisoner violence was not showing the same decline. The local site was far more violent than the category C site, where prisoners felt much safer. Violent incidents were not routinely investigated, so the nature of the high levels of violence was not fully understood. The most serious perpetrators of violence were managed using a challenge, support and intervention plan, and many had good plans, with a range of tailored interventions and actions.

1.13 The culture of the prison did not promote hope and optimism, and there was little to incentivise good behaviour. Standards of behaviour were set too low. Monthly safety meetings discussed a wide range of useful data, but this did not lead to actions to reduce violence or promote better behaviour.

1.14 We could not be confident that all use of force was proportionate, necessary and justified as a result of weaknesses in governance. Some incidents were not recorded, documentation lacked detail, statements were missing, and body-worn cameras were not always used to capture evidence.

1.15 Living conditions in the relocated segregation unit had marginally improved, although cells remained dingy. Cells on the ground floor of the segregation unit were overlooked by prisoners on the vulnerable prisoner exercise yard. This meant unscreened toilets were in view and that some segregated prisoners could shout abuse to the vulnerable prisoners while they exercised.

1.16 Staff–prisoner relationships in the unit remained a strength and they showed good knowledge of the prisoners in their care. The average length of stay was short and there was an emphasis on reintegration, helped by good, regular and detailed input from mental health and psychology teams.

1.17 Security arrangements on the local site were broadly proportionate to the risks posed, but this was not the case on the category C site, where

prisoners were locked onto landings, unable to move between locations unescorted. The prison identified drugs as its main threat – and some measures to address the problem had been put into place – but the drug strategy was too generic to be effective and lacked a specific local action plan to improve outcomes. Demand for drugs was inevitably exacerbated by a severely restricted regime.

1.18 Levels of self-harm had reduced on the local site since the last inspection but remained among the highest of all local prisons. The safety strategy was aligned with the risks that the establishment faced, but not enough use was made of the impressive range of data collated or the action plan to improve safeguarding outcomes.

Respect

At the last inspection of Winchester, in 2019, we found that outcomes for prisoners were not sufficiently good against this healthy prison test for the local site and reasonably good at the category C site.

At this inspection, we found that outcomes for prisoners remained not sufficiently good on the local site and reasonably good at the category C site.

1.19 A very restricted regime and staffing shortfalls were having a severe impact on the opportunity to develop meaningful and supportive relationships between staff and prisoners. We saw some skilful management of some challenging behaviour, but very little effective key work (see Glossary) was taking place.

1.20 Too many prisoners shared cells designed for one. Some cells were in a poor state, with insufficient furniture, large amounts of graffiti, and scaled and dirty toilets. There were not enough working showers for the population on both sites because of problems with the water supply. Too many prisoners went for days without a shower and did not have regular and reliable access to clean clothes and bedding.

1.21 In our survey, only 36% and 30% of respondents at the local and category C sites, respectively, said that the food was good, and 45% and 46%, respectively, said that the shop sold the things they needed. There was little evidence of consultation with prisoners leading to positive change.

1.22 Prisoners had little faith in the application system and there was no analysis of available data to address common issues. The complaints system was well managed and oversight was good. Access to legal services was adequate.

1.23 The strategic oversight of equality had improved with the arrival of a dedicated manager, but so far insufficient progress had been made. A strategy document identified priorities for protected groups and data analysis identified potential disproportionate treatment, but neither had led to sufficient action to improve outcomes for prisoners. Consultation

with some protected groups had only recently restarted, which left the prison poorly placed to understand needs fully. Investigations and responses to discrimination incident report forms had improved. Despite being under-resourced, the chaplaincy had continued to provide strong pastoral support throughout the pandemic, but opportunities for corporate worship remained too limited.

1.24 Health care staff delivered a wide range of appropriate services and had successfully managed four COVID-19 outbreaks and the vaccination programme. There were vacancies in all clinical disciplines. Clinics and secondary care appointments were regularly cancelled due to HMPPS staff shortages, which caused delays in access to care. No progress had been made to address the environmental deficits within the health care unit and clinical rooms. There was good management of patients with long-term conditions, but there were increasing waits for mental health services, including psychology and initial assessment. The substance misuse team provided a valuable service, although group work still had not restarted after the easing of the pandemic restrictions.

Purposeful activity

At the last inspection of Winchester, in 2019, we found that outcomes for prisoners were poor against this healthy prison test for the local site and poor at the category C site.

At this inspection, we found that outcomes for prisoners remained poor on the local site and the category C site.

1.25 Restrictions to time out of cell were having a detrimental effect on prisoners' physical and mental health, and their motivation to progress. On the local site, most prisoners had about an hour and a half out of their cell each day, but there were also some who were unlocked for less than that. Prisoners on the category C site were unlocked onto the spurs of their landings for most of the day, but too few prisoners on either site had access to any purposeful activity.

1.26 Too many prisoners were unemployed or not yet allocated to any activity. There were insufficient activity spaces to meet the needs of the population, and the curriculum for work was too narrow. The work available to those on the local site was inadequate, both in quantity and quality. Vocational training was available only to prisoners from the category C site, and only benefited a very small proportion of prisoners.

1.27 Too few prisoners were yet to have an induction to education. The quality of in-cell learning packs was too variable and did not always match the level of learning for which they were intended. Teachers and instructors did not establish prisoners' existing skills and knowledge effectively, or plan learning sequentially. Too many prisoners with a learning difficulty or disability did not develop the skills and knowledge they needed to succeed in the future.

1.28 Most prisoners were not challenged by their workshop or wing work role, or were allocated activities that did not match their needs or interests. Instructors did not monitor prisoners' progress in their subjects or in relation to employability skills adequately.

1.29 Attendance at education, vocational training and work was far too low and prisoners were often late to their lessons. Staff did not take into account the needs, abilities or aspirations of prisoners when allocating them to work and education activities.

1.30 Leaders and managers did not focus sufficiently on the quality of education, skills and work. There was too little impact from the functional skills strategy that leaders had recently put in place; too few prisoners were prepared effectively to sit examinations for functional skills English and mathematics, and only a few passed them.

Rehabilitation and release planning

At the last inspection of Winchester, in 2019, we found that outcomes for prisoners were not sufficiently good against this healthy prison test for the local site and reasonably good at the category C site.

At this inspection, we found that outcomes for prisoners remained not sufficiently good on the local site and at the category C site.

1.31 Social visits were available to all prisoners. Access was restricted to two visits each month – including for remand and enhanced prisoners – even though there were spaces available. Spurgeons family workers provided excellent support to prisoners with family issues and broader resettlement needs, and had resumed delivery of group family interventions in December 2021.

1.32 Work to reduce reoffending was hampered by the lack of a current needs analysis, a strategy setting out the work that needed to be done and an action plan to identify and measure progress across the resettlement pathways. Multidisciplinary meetings to oversee and drive reducing reoffending work had only just restarted after the easing of the restrictions and records were poor. Vacancies and cross-deployment of operational prison offender managers had led to weaknesses in some core functions, such as delays in home detention curfew applications and recategorisations.

1.33 Oversight and timeliness of offender assessment system (OASys) assessments were good. Most eligible prisoners had a current sentence plan of reasonable quality, but prisoners' knowledge of these plans was limited in too many cases. Levels of contact with prisoners were often insufficient to support progression.

1.34 Processes for identifying prisoners who posed a risk to the public had improved and monitoring arrangements were now better coordinated. The prison's contributions to multi-agency public protection

arrangements (MAPPA) meetings in the community were mostly of good quality.

1.35 Leaders had not assessed the treatment needs of their population and there were no accredited interventions on either site. However, a small number of prisoners had benefited from interventions from Spurgeons, the education team and the chaplaincy, which facilitated a victim awareness course.

1.36 On average, a total of 80 prisoners were released from the establishment each month. Leaders did not collate and review data on prisoner outcomes, such as sustainable accommodation and work on release. We saw evidence of good work to support prisoners approaching release, although details were often not settled until their last few days in the prison.

Key concerns and recommendations

1.37 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.

1.38 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.

1.39 Key concern: Delivery of priorities set at the last inspection was slow, and the plan to deliver the basics of custody had not been executed well or delivered the results intended. Standards were not set sufficiently high, and leaders had become complacent about some poor outcomes.

Recommendation: Leaders should ensure that the basics of custody are delivered consistently and to a high standard.
(To the governor)

1.40 Key concern: Staffing levels were not sufficient to deliver a decent regime and current recruitment did not keep pace with staff departures. Relationships between staff and prisoners inevitably suffered because of a lack of meaningful interaction and frustration caused by the inability to get the simplest tasks done. Fragilities within the management structure limited oversight, role modelling and support for staff.

Recommendation: Recommendation: Staffing at all levels should be sufficient to deliver a full regime, support constructive relationships and facilitate leaders to carry out their line management duties.
(To HMPPS)

1.41 Key concern: Winchester remained one of the least safe prisons in the country. Incidents were not always investigated to help leaders gain a

full understanding of the underlying causes of violence to enable them to devise a responsive strategy. Staff were unfamiliar with some key processes and the culture of the prison did not motivate good behaviour.

Recommendation: A thorough analysis of the causes of violence should be used to devise a safety strategy that addresses deep-seated cultural issues that leads to a reduction in the high levels of violence and make the prison safe.
(To the governor)

1.42 Key concern: Documentation to justify the use was force was often incomplete. Body-worn video cameras were not routinely operated during incidents, and recordings of incidents, both planned and spontaneous, were not always retained. Some incidents were not recorded through the HMPPS incident reporting system. Governance of the use of force was poor. As a result of these deficiencies, HMPPS could not be assured that all force used was proportionate, necessary and justified.

Recommendation: Leaders should provide rigorous oversight of the use of force, ensuring appropriate accountability through accurate reporting, activating body-worn cameras and retaining footage as evidence and to inform learning.
(To the governor)

1.43 Key concern: Self-harm rates remained high in comparison with those at similar prisons, and the establishment was not making effective use of available data to understand the underlying causes of self-harm. There was insufficient quality assurance and inadequate peer support for prisoners who were in crisis.

Recommendation: Data analysis should be used to understand the root causes of self-harm, and the results should inform an effective action plan that leads to a reduction in incidents and support prisoners at times of crisis.
(To the governor)

1.44 Key concern: Too many prisoners on the local site lived in cold, poorly equipped and dirty cells. Many cells were overcrowded. The 'decency policy' was not being implemented, and staff and many prisoners had become desensitised to the poor conditions that many prisoners were held in. Access to basics, such as a daily shower, cleaning materials, clean bedding, clothing and stored property, was too often very poor.

Recommendation: All prisoners should have access to the basics of custody, including in-cell furniture, daily showers, cleaning materials, clean bedding and clothing, and their stored property.
(To the governor)

1.45 Key concern: Staffing challenges were having a detrimental impact on the delivery of mental health and pharmacy services, as well as on access to clinics and secondary care. This resulted in delays for mental

health assessment, limited access to a pharmacist and delays in treatment.

Recommendation: Staffing levels in health care should be sufficient to provide appropriate support, training and clinical supervision in order to deliver good patient care.
(To the health partnership board)

1.46 Key concern: Prisoners had insufficient time out of cell and access to purposeful activity. Many prisoners on the local site spent about 23 hours a day locked in their cells, and some even longer. There was insufficient activity across both sites, which led to frustration and a detrimental impact on mental and physical well-being.

Recommendation: All prisoners should have adequate time out of cell to conduct domestic tasks, engage in purposeful activities and socialise with peers.
(To HMPPS and the governor)

1.47 Key concern: Leaders and managers had not considered the quality of teaching and assessment, and had focused too much on compliance and processes. They did not help teachers or instructors to improve their teaching and training practices effectively.

Recommendation: Leaders should make sure that they evaluate fully the quality of teaching and assessment. They should identify and implement actions that will improve teachers' and instructors' teaching practices.
(To the governor)

1.48 Key concern: Leaders had not taken sufficient, or effective, actions to make sure that prisoners attended their education and work activities, and there were too few spaces for the size of the population. Too many prisoners had their progress disrupted by their inability to attend activities and their frequent lateness because of substantial delays to the regime.

Recommendation: Leaders should maximise prisoners' opportunities to access education and work, and enable them to attend their allocated activities on time.
(To the governor)

1.49 Key concern: Leaders prioritised a minority of the population for face-to-face inductions, allocation to activities and access to advice and guidance. They did not understand the needs, experience or aspirations of most of the population.

Recommendation: Leaders should allocate prisoners to activities fairly, taking into account their needs and aspirations, and give them equal access to essential services, including induction and careers advice and guidance.
(To the governor)

1.50 Key concern: Leaders and managers did not make sure that teachers and instructors provided prisoners who had a learning difficulty or disability (LDD), or for whom English was not their first language, with the support they needed to succeed. Too few prisoners with known LDD or English for speakers of other languages (ESOL) needs developed the skills and knowledge they needed for their next steps.

Recommendation: Leaders should make sure that teachers and instructors adapt their teaching practices to take account of prisoners' known learning needs. Support staff should make sure that they identify appropriate support strategies, which they share with teachers and instructors, so that prisoners make good progress in their learning and training.
(To the governor)

Notable positive practice

1.51 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.

1.52 Inspectors found two examples of notable positive practice during this inspection.

1.53 A flow-chart was provided with every complaint response, to highlight prisoners' routes of appeal if needed. (See paragraph 4.23)

1.54 The pharmacy team contacted the patient's GP to obtain clinical information, and if no response had been received within 72 hours, a further contact was made. (See paragraph 4.95)

Section 2 Leadership

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

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 Leaders, partners and staff at the establishment had worked together to manage the prison through two difficult years, in which there had been four COVID-19 outbreaks. Shortly before the inspection, the prison had moved temporarily to stage four of the Her Majesty's Prison and Probation Service (HMPPS) recovery plan, the most restrictive level of the national framework recovery model (see Glossary). During this time, leaders had maintained delivery of social visits and some limited activities. At the time of the inspection, the prison was in stage three of recovery.

2.3 Leaders had employed some innovative methods to communicate key messages. The governor shared information with staff through a messaging platform and recorded video messages to prisoners which were transmitted through the prison television channel.

2.4 Priorities set by leaders were appropriate and included recovery from COVID-19 and improving safety outcomes. However, delivery against the priorities was slow. At the last inspection, the governor had rightly identified the need to ensure that the basics of custody were in place to pave the way for further improvement. The Chief Inspector at the time highlighted the need for leaders to focus on the basics of custody, which would include the ability for prisoners to keep themselves and their living area clean. Over two years later, the strategy to deliver this priority (known locally as 'REAL' – relationships, environment, activities and leadership; see Glossary) had still not yielded the results intended (see key concern and recommendation 1.39).

2.5 Leaders had also failed to reduce violence sufficiently, which meant that the establishment remained one of the least safe in the country. Too many prisoners still lived in very poor conditions, frustrated by the inability to get simple things done. Most leaders were passionate and well intentioned, but the high-level REAL strategy was too vague to ensure that the staff responsible for delivering the priorities understood what was required of them. Leaders had not implemented effective quality assurance to measure and improve outcomes.

2.6 The culture of the prison remained one of low expectations and apathy among prisoners and some leaders and staff. Standards were not set sufficiently high and leaders had become complacent about some poor outcomes (see key concern and recommendation 1.39). There were

pockets of good work delivered by committed individual staff, but not enough was done to motivate good behaviour and inspire prisoners to do their best. Leaders had failed to establish the category C site as a rehabilitative unit offering meaningful progression, despite it being a key concern and recommendation in our last inspection report.

2.7 Relationships with partners were well established and generally positive, but in important areas such as education and maintenance this was not leading to improved outcomes. Ofsted judged the provision of education, work and skills to be inadequate, concluding that this area had not been given sufficient priority by prison leaders. Leaders had not capitalised on consultation with prisoners to effect positive change and influence a more positive prison culture.

2.8 The ability of leaders to deliver the priorities had sometimes been hampered by COVID-19 outbreaks, the associated national restrictions and severe staffing shortages at all levels (see key concern and recommendation 1.40). Staff on the local site reported being tired and not sufficiently supported – again, a casualty of staff shortages and fragility within the management structure, which often limited oversight, role modelling and support for staff. There was evidence that leaders were brave in their efforts to tackle corruption in a minority of staff; this delivered an important message to staff and prisoners.

2.9 Data were not used sufficiently well to inform planning and improve outcomes. There were a number of promising but embryonic plans to make the improvements needed, but leaders were struggling to implement them.

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 Prisoners continued to experience delays at court before being transported to the establishment. In our survey of the category C site (Westhill), only 10% of respondents said that they had been given helpful information before arrival at the prison, which was far worse than at similar prisons (24%). This was also raised as an issue by category C prisoners during the inspection. When prisoners arrived at the prison, they disembarked from escort vehicles promptly and were not routinely or unnecessarily handcuffed for the short walk to reception. All prisoners destined for both the local and category C sites went through the arrival process in the same reception area.

3.2 Reception staff were welcoming to prisoners and there had been some physical improvements to the reception area. However, holding rooms remained stark and uninviting, with little furniture or reading material to inform new arrivals about what to expect during their time at the establishment. All prisoners went through the recently installed body scanner, although records did not show any substantial finds from this and not all staff had received relevant training in its use (see also paragraph 3.31).

3.3 Improvements had been made to initial safety screening to identify risk, and all prisoners were interviewed in private by a member of the reception team. Several peer support orderlies were employed in the reception area, although not all were trained Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners; see also paragraph 3.38). On completion of reception screening, new arrivals were moved to the first night centre, where they received an additional safety interview which presented a further opportunity to identify risk. Prisoners were moved from reception one by one, rather than in groups, which prolonged the reception process unnecessarily. In our survey, only 47% and 44% of respondents on the local and category C sites, respectively, said that they had spent under two hours in reception.

3.4 All new arrivals destined for the local site were moved to either landing D4 or overspill cells on C wing. Where space permitted, new arrivals for the category C site were taken straight to Westhill. In our survey for both sites, respondents reported more negatively than in similar prisons

across several aspects of their early days experience. Fewer said that they had been able to access a shower, telephone call or a clean and well-equipped cell on their first night. Prison leaders told us that all new arrivals could make a telephone call, subject to public protection procedures. However, cells that were identified for new arrivals had damaged telephone cabling, which meant that telephones could not be used. Many cells also lacked basic furniture and were grubby and unwelcoming, with offensive and threatening graffiti on the walls.

Damaged telephone cabling in cells

3.5 While there had been some improvement since the previous inspection, not all prisoners received important elements of their induction. This was often because of a lack of available staff and redeployment to fill shortfalls elsewhere within the establishment. In our survey, only 63% of respondents at the local site said that they had received an induction, which was substantially worse than at similar prisons (76%). We spoke to several prisoners who had not been offered a shower, exercise in the fresh air or had access to a cell telephone since their arrival five days earlier. A foreign national prisoner we spoke to had not been able to telephone his family since arriving at the prison, and they were unaware of his location. He had not been supported to make contact with his embassy (see also paragraph 4.36).

3.6 Staffing shortfalls had clearly had an impact on prisoner outcomes during the early days at the establishment (see paragraphs 2.8 and 4.1). When induction was conducted, this was often at the cell door, and important gym and education assessments were often not completed to the required standard. Prison leaders were aware of the issues and had recently appointed a dedicated manager to improve the early days offer. This had led to some initial strengthening of

processes, such as the introduction of a basic spreadsheet to track completions, but greater emphasis was required to make sure that all basic elements of early days need were met consistently (see key concern and recommendation 1.40).

Recommendation

3.7 **All prisoners should be provided with basic services, such as access to showers and telephone calls, on their first day and an adequate induction programme in their first few days at the prison.**

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

3.8 Overall levels of violence for the previous 12 months were similar to those reported at the time of the last inspection and remained high. The rate of assaults on staff was the highest of all local prisons (with 418 incidents per 1,000 prisoners over the last 12 months), and more than three times the average for this comparator group. However, the monthly number of assaults on staff had been on a downward trend over the previous 12 months. The level of violence between prisoners also remained one of the highest of all local prisons and, of concern, did not show the same consistent decline as with violence on staff (see key concern and recommendation 1.41).

3.9 Almost all violent incidents occurred on the local site, where prisoner's perceptions of safety remained high. Twenty-four per cent of survey respondents said that they currently felt unsafe. In stark comparison, only 3% of prisoners on the category C site said that they felt unsafe (see key concern and recommendation 1.41).

3.10 Despite it being identified as a priority, the safety team was not sufficiently or consistently resourced to make the prison safer (see also sections on leadership and safeguarding). This meant that violent incidents were not routinely investigated, and the nature of the high levels of violence, particularly among young adults, was not fully understood. This resulted in missed opportunities to identify prisoners subject to bullying, threats or intimidation (see key concern and recommendation 1.41).

3.11 There was no formal support for victims of violence, and, as a result of staff shortages, the safety team was unable to conduct regular post-incident welfare checks (see key concern and recommendation 1.40). There were dedicated landings both for vulnerable prisoners and newly arrived prisoners. Vulnerable prisoners we spoke to told us that they

regularly experienced verbal abuse which was not challenged by staff (see also paragraph 3.24, and key concern and recommendation 1.41).

3.12 A wide range of useful violence data was discussed at the monthly safety meetings, but these were not used routinely to inform strategic actions to reduce violence or promote better behaviour across the prison (see also paragraph 3.37 and key concern and recommendation 1.42). The weekly safety intervention meeting was still conducted via telephone dial-in, even though other meetings were once again taking place in person. Despite this, the meeting provided an effective forum for multidisciplinary input to discussions about how to manage some individual prisoners, often with complex needs.

3.13 The most serious perpetrators of violence were managed using a challenge, support and intervention plan (CSIP; see Glossary), and many of these plans were good, with a relevant range of tailored interventions and actions. Promisingly, the prison had just started to open CSIPs for prisoners with a known history of violence as they entered the prison. It was too early to assess the impact of this initiative.

3.14 Although the CSIP plans we reviewed were good, the process was not well embedded on the wings. The prison had initiated a requirement for CSIP case managers to have received training, but this was currently suspended because of COVID-19. This meant that, despite the high number of assaults across the prison, only 15 prisoners were being managed using the CSIP process. Therefore, beyond the use of disciplinary procedures, too little was being done to manage or challenge perpetrators of violence (see key concern and recommendation 1.41).

3.15 There were too few incentives to promote good behaviour or foster a rehabilitative culture. The opportunity to progress to the category C site was not well promoted. Other than prisoners being unlocked for longer, behind a spur gate, the regime on the units was inadequate. Many other potentially incentivising activities, such as family days and access to release on temporary licence, were still suspended because of COVID-19 restrictions. In our survey, only 25% of prisoners on the local site said that the incentives or rewards in the prison encouraged them to behave well. The formal incentives scheme remained mainly ineffective, with little distinction between the standard and enhanced levels. The few prisoners on the basic level of the scheme did not receive support to change their behaviour. Some prisoners and staff expressed low expectations about what could be achieved at the establishment. There was too little to inspire prisoners and a sense of hopelessness could be felt across both the local and category C sites.

Recommendation

3.16 **Senior leaders and managers should create an environment that motivates, rewards and promotes positive behaviour.**

Adjudications

3.17 Our review of adjudication records indicated that hearings were conducted promptly, and adjudicating governors usually explored the underlying issues leading to a charge. However, there was no quality assurance process to ensure consistency and fairness. There were plans to improve procedural justice in adjudications, with input from the regional psychology team, which was a welcome initiative.

3.18 At the time of the inspection, there was a small backlog of about 20 adjourned charges. Too many adjudications were not proceeded with after being referred to the police. Prison leaders had carried out some effective joint working with the police to address this issue, resulting in police training for prison staff on preserving the chain of evidence.

3.19 Useful and appropriate data were gathered and presented at the quarterly segregation monitoring and review board, including monitoring for disproportionate outcomes, but it was unclear how this information was used to inform improvement. There was no scrutiny of individual adjudication records through this forum.

Use of force

3.20 There had been 335 recorded incidents of use of force in the previous 12 months, which was far fewer than at the time of the previous inspection. However, we found concerning evidence of under-reporting. Prison staff provided examples, including planned interventions, that had not been reported on the incident reporting system (IRS). We raised this issue with senior leaders during the inspection and were provided with advanced plans to improve assurance and reporting on the IRS (see key concern and recommendation 1.42).

3.21 There had been 80 separate recorded incidents of use of force since June 2021, and not all staff statements had been completed for these. The quality of the statements we reviewed was often poor, with a lack of focus and insufficient detail about who was involved and why the use of force had been necessary. Staff did not routinely switch on their body-worn video cameras (BWVCs) to capture evidence in either planned or spontaneous incidents; video footage was available for only one of the 10 incidents that we reviewed in detail. In other incidents included in our sample, staff had stated that they had activated a BWVC, but the footage had been deleted so it was not available to allow scrutiny or provide lessons for staff development. Similarly, in cases where closed-circuit television footage was available, it was not routinely downloaded for evidence. The use of force coordinator spoke honestly about the risks that the establishment faced as a result of poor governance, but they were often redeployed and not afforded sufficient time to drive improvement (see key concern and recommendation 1.42).

3.22 A use of force scrutiny meeting was held monthly and attended by senior leaders, including the governor. Attendance by other key players was variable and, as a result of sickness, there had been some months

when the meeting had not taken place. A useful range of data was compiled by the safety team each month. This included a heat map of where incidents took place and the protected characteristics of those subject to force. This data had been used to inform one meeting in October 2021 where there was a detailed discussion about use of force incidents involving black prisoners which had generated some useful actions. However, these actions, along with other key issues, had not been tracked or followed up at subsequent meetings so it was not clear if concerns had been addressed. There was little evidence to demonstrate that the data pack was used to identify and drive improvement. As a result of these deficiencies, we could not be confident that all force used was proportionate, necessary and justified (see key concern and recommendation 1.42).

Segregation

3.23 In addition, cells on the ground floor of the segregation unit were overlooked by the prisoners on the vulnerable prisoner exercise yard. This meant segregation cell toilets were in view. It also meant that some segregated prisoners could shout abuse to the vulnerable prisoners while they exercised.

Improvements to the segregation unit

Segregation yard

3.24 Segregated prisoners were not provided with a radio or chair for their cells for at least 24 hours after arriving in the unit, which was neither justified nor decent.

3.25 Staff–prisoner relationships in the unit remained a strength. The staff we met demonstrated compassion and good knowledge of the prisoners in their care. The average length of stay was short and there was an emphasis on reintegration, even for prisoners with complex needs. This work was supported by good, regular input from mental health and psychology teams.

Recommendation

3.26 **All segregation cells should be adequately equipped and include cell furniture as standard.**

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.

3.27 Security arrangements on the local site were broadly proportionate to the risks posed, but this was not the case on the category C site, where prisoners were locked onto landings, unable to move between locations on the site unescorted.

3.28 The prison identified drugs as its main threat, particularly on the local site. In our survey, 39% of respondents on this site said that it was easy to get illicit drugs. Although this was down from 59% at the time of the last inspection, it was still a far higher proportion than in other local prisons (24%). The demand for drugs was inevitably exacerbated by a severely restricted regime, boredom and a lack of optimism that things would improve.

3.29 Some measures to address the problem had recently been put into place, including the photocopying of all social mail and the appointment of 14 new designated security liaison officers. These officers had been trained by the security department to raise awareness of security issues among new and inexperienced wing staff, including intelligence reporting and the threat posed by drones.

3.30 Staff shortages often meant that the prison's response to the identified threat of drugs was not sufficiently robust to detect and deter the entry of illicit substances. For example, there were not enough trained staff to make sure that all new arrivals were put through the body scanner (see also paragraph 3.2); just over half of requested cell searches and only one-quarter of suspicion-led drug tests had been completed in the previous 12 months; and the new enhanced gate security processes were not yet fully operational (see key concern and recommendation 1.40).

3.31 The establishment drug strategy was too generic to be effective and lacked a specific local action plan to reduce the supply of illicit substances.

3.32 The flow of intelligence into the security department was reasonable, with an average of 650 intelligence reports received per month in 2021. These were collated, analysed and disseminated well, with no backlog.

3.33 Prison leaders worked effectively with the police when staff wrongdoing was suspected, and this had yielded some positive results. There was also good inter-agency work to help in the management of gang problems and potential extremism.

Recommendation

3.34 **The prison should take robust action to reduce the availability of illicit drugs and alcohol.**

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

3.35 There had been two self-inflicted deaths since the previous inspection. Leaders had made some improvements in relation to the implementation of action plans following investigations into deaths in custody by the Prisons and Probation Ombudsmen (PPO). The prison now received welcome support from the Her Majesty's Prison and Probation Service (HMPPS) group safer custody lead, to implement and track the progress of PPO action plans.

3.36 HMPPS data identified that about two-thirds of all new arrivals had a history of self-harm. Levels of reported self-harm had reduced since the last inspection, although at the local site remained among the highest of all comparable prisons. Although there had been an upward trend on the local site during 2021, data showed that levels had been reducing again over the previous three months, which was encouraging. There had been no detailed analysis of data to identify trends such as seasonal variations and no review of heat maps that identified times and locations where self-harm was more likely to occur (see key concern and recommendation 1.43).

3.37 In our survey of both the local and category C sites, only 40% and 43% of respondents, respectively, who had been supported through assessment, care in custody and teamwork (ACCT) case management said that they felt cared for by staff. However, during the inspection we identified some impressive examples of care for prisoners in crisis, despite the safety team being constrained by staffing shortfalls. The sample of ACCT documentation that we reviewed was of mixed standard, and many records and care maps were incomplete. Prison leaders were aware of the risks that these shortfalls presented, but there was no regular quality assurance to address the issues. When staff had sufficient time to make entries in the ACCT documentation or electronic case notes, these were of a reasonable standard and reflected good levels of care.

3.38 At the time of the inspection, there were just three Listeners for both the local and category C sites, which was insufficient. Access to Listeners was poor, which was reflected in our survey, where just 19% and 22% of respondents on the local and category C sites,

respectively, said that it was easy to speak to a Listener. The Listeners and also the Samaritans who attended the prison to offer support gave examples where the work of the former had been unnecessarily impeded by prison staff. A training course was due to take place shortly after the inspection, to increase the number of Listeners in place.

3.39 The safety strategy had recently been reviewed and was now more comprehensive, reflecting the risks that the establishment faced, such as the pressures experienced by young adults in custody. However, shortfalls and cross-deployment of staff in the safer custody team hindered their ability to drive and deliver the strategy effectively. The action plan that should be aligned to the updated strategy was out of date and many of the actions were incomplete.

3.40 The safety intervention meeting considered those most at risk of self-harm and was reasonably well attended (see paragraph 3.12). By contrast, there was less prison-wide commitment to the monthly safer prisons meetings. This forum failed to make effective use of an impressive range of data, produced by a recently appointed safety analyst, to drive improvement and reduce levels of self-harm (see key concern and recommendation 1.43).

3.41 The impact of staffing shortfalls and lack of effective planning had been identified by the deputy governor. In response, he had recently introduced new two-monthly safety plans to regain a focus on safety. While these plans were not yet sufficiently focused on all aspects of safety and had not yet reduced self-harm, they provided a sensible way forward.

Recommendation

3.42 **Safer custody staff should be given sufficient time to provide essential care for those at risk of self-harm.**

Protection of adults at risk (see Glossary)

3.43 In 2020, the prison had reviewed the memorandum of understanding that encompassed social care (see paragraph 4.71) and adult safeguarding. Meetings had been restricted because of COVID-19, but contact had been maintained between the prison and the Hampshire Adult Safeguarding Board (HSAB), with support from the HMPPS regional safety lead.

3.44 Before the inspection, the prison had produced a leaflet for staff that provided useful information on adult safeguarding. Despite this, there was still a lack of understanding among staff about the local policy, adult safeguarding principles and reporting procedures.

3.45 There had been no referrals to HSAB during the previous 12 months.

Recommendation

3.46 **All staff should receive sufficient guidance on local safeguarding reporting procedures that includes how to identify and protect any**

prisoner whose vulnerability places them at risk of harm, abuse or neglect. (Repeated recommendation 1.56)

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 A chronic shortage of frontline operational staff at the prison, combined with the very restricted regime in place, made it difficult to develop productive staff–prisoner relationships. Staff had little time to deal with everyday issues for prisoners or provide the support they needed, which inevitably led to prisoner frustration at not being able to get simple things done (see key concern and recommendation 1.40).

4.2 Our survey results on the local site were much worse than at similar prisons across a wide range of relationship questions. On this site, 57% of respondents said that staff treated them with respect, which was far worse than on the category C site (84%). Both surveys indicated that fewer prisoners than at the time of the last inspection had a named officer or someone who had checked in on them in the last week. Key work (see Glossary) had virtually stopped and we found almost no meaningful entries in the electronic case notes we sampled (see key concern and recommendation 1.39).

4.3 Staff continued to use surnames routinely when addressing prisoners and it was not uncommon to hear surnames bellowed from the ground floor to summon prisoners from around the wing. Additionally, staff would unnecessarily yell ‘exercise’ and other orders at the top of their voices when in the vicinity of those they were addressing. Not only was this unnecessary, but it also demonstrated a lack of insight into the impact of shouting on those who had suffered trauma in the past.

4.4 There were also examples of friendly and supportive interactions between staff and prisoners. We observed a relatively new member of staff dealing patiently with some very irate prisoners on the induction landing who were throwing liquid and objects through their observation panels. There was also evidence of caring work with prisoners who were being supported through the assessment, care in custody and teamwork (ACCT) case management process.

The C4 induction landing

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

4.5 The prisoner survey indicated that living conditions on the local site were far worse than in similar prisons and, in many areas, worse than at the time of the last inspection. On the local site, most prisoners shared cells designed for one. Despite numerous posters on wings displaying 'what good looks like', far too many cells were in a very poor state, with insufficient furniture, and in some cases none. Throughout the inspection, prisoners complained to inspectors about having nowhere to store possessions safely. Many cells contained large amounts of, often offensive, graffiti which went unchallenged. Prisoners, locked in their cells for most of the day, had to eat their meals next to dirty, uncovered and unscreened toilets. A 'decency policy' had recently been introduced, but there was little evidence of its implementation. Senior leaders also informed inspectors that a large amount of furniture had been bought, but, again, this was not evident during the inspection (see key concern and recommendation 1.44).

Poorly equipped and dirty cell

HMPPS 'What good looks like' posters

4.6 On the local site, there was very poor access to daily showers due to a lack of hot water and regime restrictions, especially at weekends. Access to clean clothing and bedding, cleaning materials and stored property was also poor. This was reflected in our survey results on these issues, which were far worse than at similar prisons and at the time of the last inspection. Managers, staff and prisoners told us how difficult it had been to obtain sufficient supplies of clothing and bedding. It was therefore disappointing to see rubbish bags full of discarded clothing, with no consideration of recycling. Prisoners in many of the cells on the top landings complained of being cold and having to sleep in their clothes. Most had been issued with a cotton bed sheet and thin single blanket on arrival and had been unable to secure additional bedding. Windows in some of the cells were ill fitting and draughty, leading to the already limited bedding being used as draught excluders on windows.

Window draught excluder in a cell on the local site

4.7 Most of the showers on the local site had been refurbished to a decent standard, but half remained out of use because of problems with water pressure. Staff and prisoners alike commented on this, with staff stating: ‘We have 45 minutes to shower up to 75 men in eight showers that inevitably run cold halfway through’ (see key concern and recommendation 1.44).

Refurbished but out-of-use showers

4.8 Overall, living conditions on the local site were among the worst we have seen.

4.9 On the category C site, our survey results were generally similar to those at comparator prisons and at the time of the last inspection.

4.10 Water supply was also an issue on the category C site, and on two occasions during the inspection there were no showers in operation. Some shower areas were in a poor state of repair, with cubicle walls crumbling, allowing water to seep into the brickwork and surrounding floors (see key concern and recommendation 1.44).

Shower wall on the category C site

4.11 Most communal areas were reasonably clean on the local site, but category C areas were untidy and grubby. There was no one taking responsibility for cleaning and the unit felt neglected. Officers were located in distant offices and were not setting standards sufficiently high for a category C population (see key concern and recommendation 1.44). External areas of the category C site were pleasant, but few prisoners could access the gardens, with most restricted to the fenced-in exercise yard. Compounded by a lack of purposeful activity and limited opportunities to progress, category C prisoners were not treated well at the establishment.

4.12 Response times to cell call bells had markedly improved on the category C site, but continued to be poor on most of the local site. A monitoring system was in place on both sites and this provided further evidence of our observations of some cell bells remaining unanswered for long periods. On occasion, there were no officers patrolling landings to be able to respond to cell bells.

Recommendation

4.13 **Cell bells should be answered within five minutes, with any delays being investigated and remedied.**

Residential services

4.14 In our survey of the local and category C sites, 36% and 30% of respondents, respectively, said that they thought the food was good, and 28% and 38% that they got enough to eat. Food was a standard agenda item at the prisoner council (see paragraph 4.21) and a twice-yearly survey was used to inform provision.

4.15 The four-week menu cycle provided a range of choices, including healthy options and specialised diets.

4.16 Lunch was served very early, at 11am, and the evening meal service started at 4pm. Staff shortages meant that lunch (a cold meal) was often served at cell doors on the local site, again limiting the amount of time that prisoners could spend out of their cells.

4.17 Very few servery workers had been trained in food hygiene and there was a shortage of personal protective equipment for food service (see also paragraph 5.26). The kitchen and food areas were generally clean, tidy and in good order. However, on a number of occasions, there were pigeons in the C wing servery on the local site, which was clearly unhygienic.

Servery vermin

4.18 In our survey, 45% and 46% of respondents on the local and category C sites, respectively, said that the shop sold the things they needed. There had been some shortages of goods during the pandemic, but we were confident that substitute goods had been made available.

4.19 Catalogue ordering was becoming problematic because of the lack of hard-copy catalogues. The prison had yet to move to online ordering.

4.20 Shop order sheets were issued on Fridays, for delivery the following Friday. Those arriving on a Friday and over the weekend were able to place an order on the Monday, for delivery that week. This meant that the longest wait for selected goods was seven days.

Prisoner consultation, applications and redress

4.21 The prisoner council had reconvened in 2021 following the easing of some COVID-19 restrictions, and met monthly. Representatives from all residential units attended, with a selection of staff from across the prison. Until recently, there was little evidence of attendance by senior leaders, indicating that this valuable vehicle for consultation had not been given sufficient priority. There were no individual sub-committees to inform the council and we were not confident that the prisoners attending the forum represented the experiences of their peers; for example, the January 2022 meeting reported that there were 'no issues with cell furniture' (see paragraph 4.5).

4.22 In our survey, only 30% of respondents on the local site said that there was consultation in place and few prisoners that we spoke to were aware of who to speak to on the prisoner council to raise any issues.

4.23 In our survey, and in conversations during the inspection, prisoners repeatedly expressed dissatisfaction with the application process, with many claiming that they were not answered. An effective tracking system allocated a unique number to each and followed it until it was responded to. A residential governor quality assured 10% of applications daily, and the samples we reviewed were of reasonable quality. Tracking procedures provided a good range of data, although these were not used well to identify trends and emerging issues. Inspectors speculated that prisoners' frustrations arose from the answers they received rather than the system itself. For example, we identified that a large proportion of applications were requests for work or to see an offender manager, but neither of these things were readily available. It was hard to reconcile the negative perceptions of prisoners with the apparent robustness of the system, but leaders needed to examine this issue in more detail to improve prisoner confidence.

4.24 The complaints process was well managed, with an impressive level of scrutiny applied. All complaints were reviewed by the complaints clerk, with a further 10% being quality assured by a senior manager. The responses we saw were courteous and addressed the issues raised. When complaints were used inappropriately, a sensible approach of explaining and enabling the correct process was applied. All responses included a flow-chart of 'what next', which identified routes of appeal if needed. Additionally, if the complaints team perceived a discriminatory element to a complaint, they automatically transferred it to a discrimination incident report form (DIRF; see paragraph 4.34). Monitoring and oversight were good and data were used effectively to identify emerging issues, which were then reported to the senior leaders meeting.

4.25 Access to legal services was reasonable and a bail information officer helped prisoners to obtain bail where it was applicable.

4.26 The provision of legal visits was adequate. Most of these took place by secure video calling (see Glossary), although face-to-face meetings

were also still available. At the time of the inspection, there were appointments available during the coming week and thereafter.

4.27 The library held a stock of legal texts, and other documents available online could be printed on request. However, access to the library was restricted, which made the process more challenging in a restricted regime.

4.28 Prisoners complained that legally privileged mail was opened routinely by staff. We were not confident that processes were sufficiently robust or that there was adequate recording of such events.

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) 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

4.29 The strategic oversight of equality had improved with the recruitment of a full-time diversity and inclusion manager. The strategy and delivery plan were well informed, with clear and relevant priority areas, based on a sound analysis and understanding of data trends. A complementary action plan identified appropriate activities; the team clearly understood the challenges and gaps in the current equality provision. Despite this solid basis, the action plan had stalled, and insufficient progress had been made against key priority areas.

4.30 A monthly dedicated equality meeting had been subsumed within the senior leadership meeting. This did not provide an opportunity for prisoner input and, while functional heads had been nominated to lead on each protected characteristic, they were not driving action or feeding back into this key meeting. Discussion at the meeting was data driven, and analysis identified potential disproportionate treatment, but the action plan was often left off the agenda and there seemed little momentum to push forward outstanding actions. This was exacerbated by the frequent redeployment of the equality officer, which left the team under-resourced.

4.31 Equality impact assessments were carried out on key policies; while some were still in development, those we saw showed an attempt to understand the potential impact on prisoners from a range of protected characteristic groups. An identified need for staff training in equality had not been prioritised, leaving a skills gap.

4.32 Four equality peer representatives had been appointed, but some were unclear on their role. Training had been delivered via an in-cell pack,

and not all had received it. Support, monitoring and oversight of the representatives was informal and irregular, and some we spoke to expressed frustration that they were unable to provide adequate support because of their skills gaps. They were not consulted formally as part of the key equality meeting, which was a critical omission, leaving them without an arena in which to feed back issues.

4.33 Consultation with prisoners from protected characteristic groups had been minimal throughout the pandemic, which had left the prison poorly placed to understand current needs fully, but there were plans to consult every two to three months across all relevant groups going forward. In the weeks before the inspection, a small number of forums had been held with young adult, black and minority ethnic, and foreign national prisoners (see section on protected characteristics).

4.34 An internal review of the process for dealing with DIRFs had identified some common themes and areas for improvement. Our scrutiny of reports in the last six months suggested that this had led to some improvements, although some issues with timeliness remained, particularly forms not being collected regularly. A need for staff training in dealing with DIRFs had been identified but not yet addressed. The responses we reviewed were polite, investigated appropriately and answered the issues raised, and most were quality assured by the governor.

Protected characteristics

4.35 About three-quarters of the prison population were white; 14% were black and minority ethnic; and 3% were from Gypsy, Roma and Traveller communities. In our survey, only 50% of black and minority ethnic respondents from the local site said that they had been treated well in reception, compared with 81% of white prisoners. Other disproportionalities identified by the prison included black and minority ethnic prisoners being over-represented in adjudications. The latter group and Gypsy, Roma and Traveller prisoners were identified as two of four key priorities within the prison's equality strategy. However, other than one forum for black and minority ethnic prisoners being held in the week before the inspection, too little was being done to understand and address the causes of these disproportionalities.

4.36 Foreign national prisoners represented 15% of the population. The prison was aware of the need to develop support for this group, and in January 2022 had introduced a strategy and held one consultative forum. Records of the forum indicated a fruitful discussion of the key issues facing this group and identified key gaps in support, but it was too early to assess any impact. Very little crucial documentation, such as for induction, was translated into key languages and this remained a major barrier for some prisoners. Data provided by the prison suggested that professional telephone interpreting services had been used only 39 times in 2021. This meant that many foreign national prisoners were unaware of key information about prison life, and those we spoke to expressed feelings of isolation and frustration.

4.37 At the time of the inspection, there were seven detainees being held post-sentence under immigration powers, two of whom had been held for over eight months and one for almost a year, which was far too long. An immigration officer attended the prison once a week, but this isolated group expressed frustration at the lack of information about progress on their cases, and casework papers continued to be provided in English only.

4.38 There was no specific provision for older prisoners, who made up about 14% of the prison population, apart from an over-50s gym session.

4.39 Twenty-one per cent of the population were under 25 years of age. 7% of whom were under 21. Young adults were disproportionately represented in higher levels of violence, self-harm and use of force incidents (see paragraph 3.22). While this had been identified as a priority area of focus for the prison, too little was yet being done to address the causes. There was no specific young adult strategy or plan, and while consultative forums had recently restarted for this group, progress had been too slow in taking forward the concerns raised.

4.40 In our survey, 52% and 29% of respondents on the local and category C sites, respectively, said that they had a disability, the former being higher than in comparator prisons we had recently inspected. At the time of the inspection, there were 23 prisoners with a personal emergency evacuation plan (PEEP), but not all staff were aware of their needs. The paperwork relating to PEEPs was not always up to date and some was missing. There had been no consultation with this group in the last 12 months, and actions identified via the equality action plan were overdue, in some cases for over a year. There was no formal peer support scheme to assist disabled prisoners, and the overall design of the prison meant that some prisoners with mobility issues faced difficulties in getting around – for example, the chapel was not accessible. Those on a social care package (see Glossary) received good support (see also section on social care).

4.41 In our survey, 8% of respondents on the local site said that they were homosexual, bisexual or of other sexual orientation. The prison had made some efforts to promote LGBT History Month, but there was a general lack of consultation and no links with community organisations to support these prisoners.

4.42 At the time of the inspection, there were two transgender prisoners. They received good support and timely case board reviews, which detailed sensitive, appropriate care, with good consideration of their individual needs.

Recommendation

4.43 **The specific requirements of prisoners with protected characteristics should be identified and met.** (Repeated recommendation S49)

Faith and religion

4.44 The chaplaincy was understaffed, which presented challenges in providing support for multiple faiths. Sessional and volunteer support was used to fill some gaps, but the needs of all religions and faith groups could not be met. The team had however, continued to provide strong pastoral care and support throughout the pandemic and had adapted provision accordingly – for example, using in-cell activities and faith packs. The small team had carried out an average of 919 face-to-face interactions a month across the prison between April 2021 and January 2022, demonstrating their efforts to maintain some level of contact.

4.45 Although corporate worship had restarted after the easing of the COVID-19 restrictions, opportunities remained too limited. Christian and Muslim prisoners could only attend a communal worship once a month, with no provision for those of other religions or faiths. The chapel was functional and well equipped, with a good selection of texts, religious artefacts and other items to cater for a range of faiths. The multi-faith room remained stark and in need of refurbishment.

4.46 The team was working hard to make sure that all prisoners who wished to see a chaplain on release were able to do so. However, given the high turnover of population on the local site, the demand for chaplaincy services remained far greater than could be met with the current staffing levels (see key concern and recommendation 1.40).

Health, well-being and social care

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

4.47 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC issued 'requirement to improve' notices following the inspection (see Appendix II: Further resources).

Strategy, clinical governance and partnerships

4.48 Practice Plus Group (PPG) was the prime provider of health care, including mental health and substance misuse services, with subcontracted services including Time for Teeth, which provided dental care. The 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 care services.

4.49 There had been four COVID-19 outbreaks, which had been well managed, with outbreak control team meetings and mass COVID-19

testing. The Office for Health and Improvement Disparities (OHID) told us that prison and health care staff had worked well together to implement COVID-19 vaccination programmes.

4.50 The head of health care and deputy manager provided a clear vision to staff and had engaged them in service improvement. We saw staff providing a respectful and caring service. There was ongoing recruitment to address staff vacancies in all clinical services, including GP and pharmacy (see key concern and recommendation 1.45).

4.51 Compliance with mandatory training was reasonable. Most staff felt supported by their line managers. Attendance at clinical supervision was not consistent and not embedded in practice, although this was acknowledged by the health care senior management team and was being addressed (see key concern and recommendation 1.45).

4.52 Patient feedback was obtained in a range of ways. PPG conducted a 'friends and family survey', and User Voice conducted surveys with prisoners. There had been a User Voice forum in November 2021, but COVID-19 outbreaks had meant that patient representatives could not meet.

4.53 Many clinical rooms did not meet infection prevention and control standards, and did not provide the necessary confidential or dignified environment. We saw evidence of water penetration, a hole in one ceiling and plasterwork that was not intact.

Room in inpatients unit

In-cell inpatient toilet

4.54 All health care staff maintained the electronic medical record, SystmOne. They had undertaken training in record keeping and the standard of entries was reasonable. Care plans ranged in quality from reasonable to very good. There was evidence in the records that foreign national patients did not always have access to professional telephone interpreting services (see paragraph 4.36 and recommendation 4.43).

4.55 Emergency resuscitation equipment was in good condition, but daily equipment checks were not always completed; this was raised while we were onsite, and addressed. An ambulance was automatically called when an emergency call was made.

4.56 Patients could submit confidential complaints, which were addressed in a timely manner. Replies were not always respectful and did not always address the key concerns that had been raised. We discussed this with the head of health care during the inspection, and training needs were promptly identified.

Recommendation

4.57 **All clinical areas should be fully compliant with infection control guidelines.** (Repeated recommendation 2.55)

Promoting health and well-being

4.58 PPG did not have a local health promotion strategy. There was a limited range of health promotion material visible across the prison and a lack of information in languages other than English (see also paragraph 4.36 and recommendation 4.43).

4.59 Screening programmes were in place and patients were appropriately referred for retinal and abdominal aortic aneurysm checks. NHS age-related health checks were not offered consistently. Bowel screening was delivered by primary care staff.

4.60 On arrival, all prisoners were offered screening for hepatitis B and C, and HIV. HIV- and hepatitis C-positive patients were referred to specialist services. Prisoners were able to access specialist sexual health services onsite, including consultant-led care.

4.61 Health care and prison staff worked together to deliver COVID-19 vaccinations across the prison. Prisoners who declined the vaccination were told that the invitation to be immunised remained open and health care staff raised it at every contact. There was a weekly offer to address outstanding childhood immunisations as well as other vaccines, such as for flu or shingles.

Primary care and inpatient services

4.62 All new arrivals received a health assessment in reception, where they were screened for urgent medical needs and could be referred to substance misuse or mental health services. We found that not all referrals were made to the mental health team promptly. All prisoners were seen for a secondary screen the following day for a comprehensive assessment, immunisation, blood-borne virus testing and sexual health screening.

4.63 Prisoners could put in a confidential application or ask staff to request a health care appointment. There was one full-time GP in post, who ran five face-to-face clinics and five remote clinics for patient review and administration. There was only a remote GP service available to cover the onsite GP's leave or sickness, which meant that patients were at risk of not being seen. Out-of-hours support was available through NHS 111 and PPG clinical leads. Nursing cover was available 24 hours a day. Nurse-led triage clinics ran daily, and managed patient needs well. We saw all staff working together to discuss patient care and address any immediate health needs.

4.64 The identification and management of patients with long-term health conditions had improved. They were all screened within one week of arrival and provided with a prompt face-to-face review. All of the care plans we reviewed had been updated and showed that patients had been provided with information and guidance on how to manage their conditions. The long-term conditions nurse carried out prompt medicine reviews and annual health checks for patients with mental health needs.

4.65 The range of health care services available included dentistry, optician, podiatry, sexual health and physiotherapy, and waiting times were reasonable. However, because of the lack of clinical rooms, nurses often had to see patients in their cell, which was not confidential.

4.66 Managers routinely reviewed the non-attendance rates for appointments. However, there was no analysis of why appointments had been missed, which could have been used to inform service delivery. Due to limited prison staff numbers, some clinics and external hospital appointments had to be cancelled and rearranged, but these were managed effectively. Patients needing urgent treatment were prioritised. Patients were not routinely told if an appointment, either internal or external, had been cancelled or rearranged, which did not meet the duty of candour we would expect (see key concern and recommendation 1.45).

4.67 The inpatient unit held up to 15 patients who needed support for either physical or mental health needs. It was staffed by uniformed officers, with support from the health care providers when needed. We saw positive interactions between patients and officers, who knew the prisoners in their care well.

4.68 The patients we spoke to in the unit said that they had little time out of cell and for showers, and there was a limited therapeutic regime available. PE staff offered inpatients the opportunity to attend the gym for exercise. Those with mobility issues had little or no opportunity to undertake activities.

4.69 Patients were brought over to the inpatient unit to attend outpatient clinic appointments, which created some problems in the shared space. The waiting area was unacceptably poor and contained an undignified toilet space and insufficient and austere seating.

4.70 Prisoners due to be released were provided with a summary of their care, information on accessing health care services in the community and a supply of medicines if needed.

Social care

4.71 There was an up-to-date memorandum of understanding between the prison, health care providers and Hampshire County Council (see paragraph 3.44), which made sure that all parties knew their responsibilities. During the COVID-19 restrictions, there had been delays in assessing prisoners, with one prisoner waiting four weeks for a social care assessment; however, the health care provider and prison had managed patients well during these times. At the time of the inspection, some patients had mobility aids and equipment that needed repair, and this was being addressed by the prison.

4.72 Hampshire County Council commissioned PPG to provide 37.5 hours a month of social care to prisoners. At the time of the inspection, eight prisoners needed support for physical needs, and those we spoke to were complimentary about the care they received. They all had good person-centred care plans. We saw caring interactions and staff knew their patients well.

4.73 There were ongoing plans to promote and raise social care awareness within the prison. There was no peer support scheme (see also

paragraph 4.40), but the County Council had funding to help the prison with ongoing training of peer support orderlies.

Mental health care

4.74 PPG provided an integrated model of mental health (MH) care, which offered a good variety of interventions and skill mix.

4.75 Although staffing levels appeared to be improving, vacancies had required PPG to stop the early days MH screening assessments previously in place, so that resources could be focused on those most at risk (see key concern and recommendation 1.45). The processes for identifying and referring those with MH needs on reception were not robust. Senior staff were aware of this problem and there were plans to reintroduce a new model, although there was no evidence of risk mitigation in the interim.

4.76 A locum covered the psychiatry vacancy and provided consistent care and management of those with acute and enduring MH problems (see key concern and recommendation 1.45).

4.77 The prison held a small number of complex and often very mentally unwell patients. Most were managed in the inpatient unit, but a few were in the segregation unit. The MH team provided care and support for these individuals and carried out assessments and transfers to MH facilities where appropriate. Eleven patients had been transferred out under the Mental Health Act in the previous seven months. Transfer times were variable, but staff managed the waiting times well. The longest wait had been 41 days, which was too long, although five patients had been transferred within 14 days from their second assessment.

4.78 The number of referrals to the MH team was high, with a quarter of the population being referred each month. At the time of the inspection, there were 33 patients waiting for an initial triage assessment, the longest wait being three weeks and two days, which was too long. Urgent referrals were seen by the duty MH worker within 24 hours. In our survey, only 22% of prisoners on the local site said that it was easy to see an MH practitioner, although this was in line with the comparator. Staff told us that this was because of the shortage of escorting officers, but this needed to be explored further (see key concern and recommendation 1.45).

4.79 Planned care was outlined in a care record, but was not easily accessible to all staff as it was dispersed within the clinical record.

4.80 An MH duty worker attended all assessment, care in custody and teamwork (ACCT) case management reviews, urgent referrals and multidisciplinary team meetings, such as the safety intervention meeting (see paragraph 3.12).

Recommendations

4.81 **Prisoners requiring treatment in hospital under the Mental Health Act should be transferred within the timescales established by NHS England and NHS Improvement.** (Repeated recommendation 2.75)

4.82 **Prisoners' mental health needs should be appropriately identified and progressed on arrival as a priority.**

Substance misuse treatment

4.83 The substance misuse team provided a good service. In the absence of regular drug strategy meetings or a local action plan, the team attended the safer custody and safety intervention meetings to discuss individual patient concerns. The security department told the team about any local intelligence or prisoners of interest, so that they could make informed decisions.

4.84 All new arrivals were screened for alcohol and/or drug withdrawals and were reviewed by the specialist clinical nurse, who was also a prescriber.

4.85 The specialist clinical nurse provided flexible prescribing based on individual need and national guidance. At the time of the inspection, 46 patients were receiving opiate substitution treatment, which was 9.5% of the prison population. Those we spoke to were satisfied with the care they were receiving. Prisoners being assessed in the clinical room on the first night centre were required to provide a urine sample for drug screening using a urinal that only screened from the waist downwards, which was inappropriate and undignified.

4.86 Clinical reviews took place jointly with the psychosocial service and were timely.

4.87 The methadone administration session we observed had small queues, adequately supervised by custody staff.

4.88 Psychosocial services had continued to deliver individual and wing-based work throughout the pandemic. There were plans to reintroduce mutual aid groups, such as Alcoholics Anonymous and Narcotics Anonymous, to the prison and to re-establish peer mentors, although no timescale had been identified.

4.89 A total of 120 patients were engaged with psychosocial interventions. The recovery-based care plans we looked at were patient centred and regularly reviewed with the patient.

4.90 Prisoners leaving the prison were offered harm minimisation advice and naloxone (treatment to reverse the effects of opiate overdose) training and supplies, as necessary. When they transferred to another prison or were released into the community, services liaised to make sure that discharge planning was effective and included details of prescribed medication.

Medicines optimisation and pharmacy services

4.91 The pharmacy service was led by a registered pharmacy technician, supported by a regional pharmacist, but lacked consistent, onsite supervision from a pharmacist. As well as a pharmacist vacancy, there were gaps in the pharmacy technician team which were covered by regular agency staff (see key concern and recommendation 1.45). All staff administering medicines were assessed for their competence.

4.92 Medicines were obtained from a pharmacy out of the area, which checked prescriptions but had no access to the rest of the clinical record. At weekends, a prescription would be dispensed by a local pharmacy or from stock. This was unaudited and there was no record of where or when, or for whom, it had been used, which was not acceptable.

4.93 Medicines were prescribed by a regular GP, psychiatrist and one non-medical prescriber. Some medicines, including lithium, were not prescribed in accordance with the standard dose or monitoring regime, but 11 patients were receiving medicines at about 10pm, which was appropriate.

4.94 Each new patient was risk assessed for medicines use at reception, although these were not routinely reassessed.

4.95 A reconciliation was undertaken of patient medications against the NHS summary care record. The patient's GP was contacted to make sure that no hospital appointments or screenings were missed. If there was no response within 72 hours, this was escalated, and they were contacted again. This was implemented following a death in custody recommendation.

4.96 Patients with serious mental ill-health had inconsistent metabolic monitoring, and the lack of pharmacy oversight reduced governance safeguards and an understanding of prescribing trends.

4.97 A Methasoft system was used to measure methadone. Patients on the category C site were not on the same wing as this equipment, so their dose was dispensed by two nurses, labelled by the machine and then transferred to the patient. This was a temporary measure used during the pandemic and we advised the team that the previous arrangements should be reinstated as soon as possible.

Recommendation

4.98 **Interim pharmacy arrangement should be in place to ensure robust governance and oversight of the service, prescribing and monitoring of medicines, and supervision of technicians.**

Dental services and oral health

4.99 Time for Teeth provided a full range of dental treatments, including aerosol generating procedures and urgent access. The surgery had an air purifier and clinics no longer included fallow time, as outlined in the

national guidelines, thereby increasing the number of available appointments.

4.100 Dental waits were severely affected by the lack of prison officers to bring patients to their appointments (see key concern and recommendation 1.40). During the inspection, 100% of the morning clinic appointments were lost for this reason, including an urgent appointment. Staff managed risk by making sure that there were slots available, so that appointments could be rebooked quickly. At the time of the inspection, 78 prisoners, across both sites, were on the waiting list, having waited up to 12 weeks. The delays mostly affected those waiting for ongoing treatment. Same-day appointments were offered for emergency care.

4.101 There was no hygienist available, and no dental health promotion sessions were provided; although some health promotion was given during individual consultations, this was not equitable with community care.

4.102 The dental surgery had recently been refurbished and had a separate decontamination room, which was well managed. Equipment, waste management and servicing were in line with expected national standards.

Dental suite

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) and are encouraged to engage in activities which support their rehabilitation.

5.1 Our survey results for time out of cell were very poor on the local site, both compared with the figures at the time of the last inspection and against comparators. Only 5% (against 42% at comparator prisons and 32% previously) said that they had enough time to carry out domestic tasks, and 84% (versus 65% and 61%, respectively) said that they spent less than two hours out of cell during the week (see key concern and recommendation 1.46).

5.2 During our roll checks, half of all prisoners on the local site were locked up. Those who were unlocked were out of their cells for only an hour and a half each day, although even that was often cut short and many prisoners had only an hour and a quarter. Only 15 prisoners could access the gym at any one time, so this had a minimal effect on time unlocked (see key concern and recommendation 1.46).

5.3 On the category C site, our survey results about the amount of time that prisoners could spend out of their cells were more positive than comparators. They were unlocked for most of the day, albeit being restricted to their landings. However, the results were far more negative than comparators about access to association or time in the open air. The large association area on this site was being used as an equipment store and, with very few jobs available, there was little for prisoners to do each day (see key concern and recommendation 1.46). The Hearn unit provided a better environment and those living there had some access to association and cardiovascular gym equipment.

5.4 Across both sites, we saw prisoners routinely sleeping their days away, unemployed and demotivated. This led to a general feeling of indolence and apathy across the prison. We were also told by staff and prisoners that the poor regime was having a detrimental effect on prisoners' mental and physical health and well-being (see key concern and recommendation 1.46).

5.5 Libraries across both sites had been closed since the start of the pandemic and there were no plans to reopen them. However, staff were proactive in adapting services and running a series of creative initiatives, such as competitions and in-cell reading clubs, which

mitigated the closure to a small extent. Analysis of data was good, and common themes were monitored and addressed.

5.6 Gym facilities across both sites were adequate but in need of refurbishment. Data were not being monitored to identify trends and there were no accredited PE courses on offer. Various inequities in access, including between wings, led to frustration among some prisoners. Staff redeployment was having a negative impact on the team's ability to run some sessions.

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.

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

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Inadequate

Personal development: Inadequate

Leadership and management: Inadequate

5.8 Leaders and managers did not identify and address weaknesses in the quality of education, skills and work activities effectively. They focused too much on operational matters and compliance with processes. As a result, they did not make sure that the quality of teaching, training and assessment was good enough to secure prisoners' progress in their learning. While managers identified and escalated to leaders the factors that had a detrimental impact on education, skills and work provision, such as attendance and punctuality, too little action was

taken to bring about any improvement (see key concern and recommendation 1.47).

5.9 Leaders and managers did not provide professional development for instructors to improve their teaching and training skills. In the case of education staff, their professional development opportunities were not sufficiently focused on improving teaching and assessment practices. Consequently, teaching weaknesses that managers had identified through quality assurance were not rectified effectively. However, most vocational training staff made sure that they remained up to date with their industry-related practical skills.

5.10 There were too few purposeful activity spaces for the prison population. About half of the population across both sites was unemployed or yet to be allocated to an activity. Too many had not completed an appropriate education induction, and not all prisoners could attend this face to face. Too many failed to return their in-cell induction paperwork or attend the induction sessions on offer. As a result, there was an increasing proportion of prisoners for whom their needs were not known, and they were not allocated to any education, skills or work activity (see key concerns and recommendations 1.48 and 1.49).

5.11 The pay policy did not disincentivise prisoners from attending education. For example, leaders made sure that prisoners could maintain a full-time pay rate through bonus payments for good behaviour and participation in face-to-face functional skills lessons.

5.12 Too few prisoners accessed education and vocational training. Leaders had not considered prisoners' existing skills, future ambitions and needs when establishing the education, skills and work curriculum. Too few took part in in-cell learning, despite the broad offer, which included English, mathematics, personal development topics and the ability to explore bespoke interests such as calligraphy, origami and coarse fishing. A small minority of prisoners could access face-to-face teaching in English, mathematics, business, art, cookery and music. Vocational training was available only to prisoners from the category C site and was too limited, with only barbering and painting and decorating on offer (see key concern and recommendation 1.48).

5.13 The work roles and workshops available provided a very narrow curriculum. The work available for the largest proportion of prisoners, those on the local site, and for vulnerable prisoners was inadequate, both in quantity and quality. Each could access only one workshop part time, or wing work. While more workshops and full-time work roles were available for prisoners on the category C site, most involved mundane tasks that did not challenge them. No work roles at either prison site were accredited, other than for the very small proportion of prisoners who completed the biohazard short course.

5.14 Managers had ambitious plans for future curriculum developments and had identified specific employment pathways for which to align the future offer. They had engaged several subcontracted providers for upcoming provision, including street works, forklift truck driving, a

patisserie with barista qualifications, a bicycle repair workshop and a television repair workshop. However, progress with these new developments had been slow, and the current prisoner population had derived no benefit from them.

5.15 Leaders and managers did not make sure that prisoners received impartial careers education. Advice and guidance staff worked only with those within 12 weeks of release, to provide generic advice and guidance on resettlement needs such as finances and housing. Staff did not identify or discuss career goals with prisoners. As a result, prisoners were ill-prepared for securing suitable employment on release.

5.16 Staff did not allocate prisoners to education, skills and work activities fairly. They failed to consider their needs, abilities or aspirations when allocating them to activities. They prioritised prisoners within two years of release for discussion at allocation meetings, leaving too many allocated to random activities that did not match their needs or interests (see key concern and recommendation 1.49).

5.17 Leaders did not monitor the proportion of prisoners who gained employment when they were released into the community. While they had access to information on the number that gained employment, they did not analyse this to assess the impact of the curriculum or to inform future plans.

5.18 Too few prisoners were prepared effectively to sit examinations for functional skills English and mathematics, and only a few passed them. Leaders had recently put in place a comprehensive functional skills strategy for the prison and made sure that sufficient outreach teachers were available to prisoners in workshops. However, these efforts had made little impact to date.

5.19 Teachers and instructors did not identify prisoners' existing knowledge and skills effectively (see key concern and recommendation 1.48). They did not help them to identify how to improve or to overcome barriers to learning. Staff did not plan learning sequentially in classes or workshops, or when providing in-cell learning packs. They did not set meaningful targets to help prisoners build on their knowledge and skills. As a result, too many prisoners repeated learning that they had already secured. However, most vulnerable prisoners in the tailoring workshop were sufficiently challenged by their work. Prisoners' work in painting and decorating was of a good standard.

5.20 Teachers and instructors did not monitor prisoners' progress in their subjects or in relation to employability skills adequately. They did not check prisoners' understanding of newly acquired knowledge or make sure that they could apply their learning. They did not use individual learning plans to help prisoners progress in their learning. Too many teaching resources and in-cell learning packs contained out-of-date references and inappropriate images, such as cartoons of thieves and racial stereotypes.

5.21 Teachers did not make sure that in-cell learning packs supported prisoners to develop new knowledge and skills. Too many in-cell learning packs were not appropriate to the level of learning for which they were intended. Prisoners found lower-level English and mathematics learning packs to be too juvenile and lacked the motivation to complete them. They were able to select any of the packs available, and staff did not assess the suitability of those they provided. Teachers did not make sure that prisoners understood the written feedback they gave. As a result, too few prisoners progressed to higher-level packs, and they repeatedly made the same mistakes in their written work.

5.22 Teachers and instructors did not provide effective support for prisoners with a learning difficulty or disability (LDD). While teachers in education had completed training in providing this type of support, they did not adapt their teaching practices appropriately, or apply individual support strategies where the need had been identified. For example, they used unsuitable fonts for prisoners with dyslexia or a sight impairment. As a result, these prisoners did not develop well the knowledge and skills they needed to progress into further learning or employment in the future (see key concern and recommendation 1.50).

5.23 Leaders did not provide adequate resources to support prisoners for whom English was not their first language. As a result, too many were enrolled onto unsuitable entry-level English classes, where they made very limited progress in improving their communication with prison staff and their peers (see key concern and recommendation 1.49).

5.24 Prisoners worked well together in their small groups. They were respectful towards each other and staff in work, workshops and classrooms. In music, for example, they welcomed the opportunity to listen to each other's compositions and valued the opinions of others. The small proportion of prisoners who accessed face-to-face education classes valued them.

5.25 Too few prisoners attended their classes, work roles or workshops. Serious staff shortages at the prison resulted in prisoners not being escorted to their activities or being moved up to an hour late (see key concern and recommendation 1.40). As a result, teachers and instructors did not know who to expect in their sessions, and prisoners missed large amounts of time in learning, training and work (see key concern and recommendation 1.48).

5.26 Prison staff did not model professional behaviour to prisoners. Too many did not wear the correct personal protective equipment (PPE; see Glossary), such as safety boots. Prisoners working in the servery had not been issued with any PPE (see also paragraph 4.17). Those in cleaning roles and in food preparation and service completed introductory courses for cleaning or food hygiene and handling too long after they had started employment. As a result, they did not gain an understanding of the need for professional hygienic standards and safety in the workplace.

5.27 Leaders had identified a need for additional, bespoke programmes for younger prisoners. However, the offer available included only cookery and music. Teachers did not help these prisoners to make informed decisions. In cookery classes, for example, staff did not promote healthy lifestyles. Prisoners cooked food, without developing any understanding of the nutritional value of the ingredients or the financial advantages of cooking from scratch.

5.28 Teachers did not make sure that the content of learning programmes, including in-cell learning packs, were appropriate to promote prisoners' understanding of equality and life in modern Britain. Too many staff did not challenge inappropriate comments and language used by prisoners. For example, they did not identify racist and stereotypical comments in prisoners' written work. As a result, prisoners received accreditation for work that promoted racist ideas, without being challenged to help them understand why these were inappropriate.

5.29 There was a very limited range of enrichment activities available. These were focused mainly on library-related tasks, such as reading, or on recreational packs supplied by education staff. Prisoners' take-up of the range of personal development in-cell learning packs was very low.

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 Leaders had made sure that social visits continued during the latest period of COVID-19 restrictions. Prisoners from both sites could access visits five afternoons a week, including weekends. Only a third of available slots had been booked in the week before the inspection. Despite this, all prisoners, whether sentenced or remand, were limited to two visits per month; this included prisoners on the enhanced regime.

6.2 The prison had a plan to reintroduce the pre-pandemic visits offer within the next three weeks, including reopening the tea bar and creche facility. However, this plan was still at an early stage and had not yet been approved.

6.3 The visits hall was well maintained, although the seating was fixed, which meant that prisoners were limited to three visitors each (plus infants who could sit on an adult's knee).

Visits hall with fixed seating

6.4 Changes to visiting arrangements during the pandemic had not been communicated well. Some prisoners were unsure how many visitors could attend and whether they all had to be from the same household. Immediately before the inspection, the visits booking line recorded message was out of date and incorrect.

6.5 In our survey, on both sites, far fewer respondents than at the time of the previous inspection said that visitors were treated respectfully by staff (local site: 24% versus 73%; category C site: 36% versus 75%). The visitors we spoke to during the inspection said that they had been treated well.

6.6 Most prisoners had access to in-cell telephones, which enabled them to maintain contact with families. However, as a result of damage to cabling in first night cells, some new prisoners were unable to telephone home (see paragraph 3.4).

6.7 Secure video calling (see Glossary) was also available and prisoners on the local site were able to have two half-hour calls a month. The prison had recently established a video calling room on the category C site, which allowed prisoners there to have additional call sessions. In the previous 12 months, take-up of all available sessions was less than 40%, but the prison had not conducted any specific consultation with prisoners about visits or video calling arrangements.

6.8 Three Spurgeons family intervention workers provided excellent support to prisoners with a range of issues, such as matters being dealt with at the family court. They were visible on the wings and maintained regular contact with the prisoners on their caseload, offering ad hoc support with broader resettlement issues and linking in with prison

offender managers (POMs). Spurgeons staff were supported by a number of prisoner peer workers, known locally as ‘Dads Reps’, who could provide information and make referrals to them.

6.9 Throughout the period of restrictions, Spurgeons workers provided prisoners with a range of family-related in-cell workbooks, and over 400 were completed in 2021. In December, they resumed delivery of group family interventions, initially with prisoners from the category C site.

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.

6.10 Approximately half the population of Winchester was sentenced, with most (42%) having category C status. The purpose of the category C site still remained unclear. Some staff and prisoners referred to it as an enhanced unit, while others considered it to be a resettlement facility. Prisoners were also confused about the role of the unit, frustrated that before transfer they had been led to believe that it would offer much more than was available to help them progress. There was little to distinguish the category C from the local site, and it did not fulfil its intended purpose as a rehabilitative environment where prisoners could progress.

6.11 Oversight of work to reduce reoffending had been poor and not well coordinated. There was no needs analysis or strategy to underpin work in this area, and no action plan to measure progress against delivery of the resettlement pathways. Little information about resettlement outcomes was collated or analysed. Multidisciplinary meetings to oversee and drive reducing reoffending work had only just restarted after the easing of recent restrictions, and attendance from other departments and records of discussion were poor.

6.12 An enthusiastic new head of reducing reoffending had been appointed, who was keen to address the weaknesses in the function, and a draft strategy looked promising, although it was still going through consultation.

6.13 Vacancies and cross-deployment of operational POMs had hampered the department’s ability to provide some offender management services in a timely manner. For example, we saw weaknesses in core functions, such as delays in home detention curfew (HDC) applications (see below) and in recategorisations (see paragraph 6.30). In spite of the staffing shortfalls, caseloads were not unrealistically high. However, levels of contact between offender managers and prisoners were not good enough. Of the 20 cases we reviewed, just under half had had sufficient contact to support sentence progression. There was no active management oversight of contact, and POMs told us that they did not

receive regular supervision where this issue could have been addressed (see key concern and recommendation 1.40).

6.14 In line with the Offender Management in Custody (see Glossary) model guidance, the more complex and high-risk cases were now managed only by probation offender managers.

6.15 Oversight and timeliness of offender assessment system (OASys) assessments were good. At the time of the inspection, 86% of eligible prisoners had an up-to-date assessment, which was better than we typically see elsewhere. This was confirmed by our case sample, where all but one of the cases we reviewed had an updated OASys assessment. The quality of the assessments completed by POMs was reasonably good.

6.16 Most eligible prisoners had a current sentence plan of reasonable quality, but prisoners' knowledge of these plans was limited in too many cases. This was confirmed by the prisoner interviews we conducted, in which many could not describe their set objectives, and even with prompting could not recall discussing sentence plan objectives with any staff. In our survey, only 11% on the local site and 46% on the category C site said that they had such a plan.

6.17 Overall progress against sentence plan targets was sufficient in less than half of the cases we inspected. All sentence plans included multiple targets, most commonly the requirement to complete offending behaviour work, and achievement against these targets was poor. Other targets included requirements to engage with substance misuse teams and secure accommodation. Only a few prisoners had employment, training and education-related targets, which was disappointing, and achievement on these was poor.

6.18 In cases of prisoners posing a risk of harm to others, we found that risk management plans had been completed in most cases. The quality of both the sentence and risk management plans was reasonably good.

6.19 Key work (see Glossary) was not operating as intended to help prisoners to progress through their sentence, and key work sessions were little more than welfare checks. Prisoners did not have a consistent key worker, with whom they could develop a rapport and trust, and there was little evidence that officers conducting these sessions had any knowledge of the prisoner's sentence plan objectives. Key workers did not routinely share information with POMs that might have been relevant to the prisoner's progression, such as categorisation reviews, or information that might help in assessing the prisoner's current risks.

6.20 The number of prisoners serving life or an indeterminate sentence remained low, at around 4% of the population. There was no additional support or provision for this group.

6.21 There was timely support for prisoners being considered for parole. In the last 12 months, 34 parole boards had been held, with 11 released,

eight not released and 15 deferred or adjourned. We reviewed a sample of prisoners who had not been released; reasons included parole boards that did not go ahead because of COVID-19 and further charges pending.

6.22 In the previous 12 months, 179 HDC applications had been reviewed. Approximately 50% of releases on HDC had been after the prisoner's eligibility date – for some, several months later. In some cases, the delay was unavoidable as the sentence imposed following a long period of remand was too short to process the application within the eligibility time. However, in too many cases we found that prison processes were slow, partly because of the offender management unit (OMU) staff shortage, resulting in unnecessary delays (see key concern and recommendation 1.40). The initial request to prisoners to supply a potential HDC address went out too late – in four cases out of our sample of 20, with fewer than 10 days to go before the HDC eligibility date – and therefore approvals were inevitably delayed.

Recommendation

6.23 **The reducing reoffending strategy should be based on a comprehensive needs analysis of the different types of prisoner held at the establishment, and be supported by a detailed action plan which is regularly reviewed to demonstrate the progress made.**

Public protection

6.24 Public protection procedures had improved. High-risk prisoners and those subject to multi-agency public protection arrangements (MAPPA) were reviewed before release. We found sufficient evidence of MAPPA management levels being notified and of appropriate risk management being discussed between POMs and community offender managers (COMs). In cases where MAPPA management levels were not confirmed, we saw evidence of POMs liaising effectively with COMs to confirm arrangements and plans. The prison's contributions to MAPPA meetings in the community were mostly of good quality.

6.25 A quarterly public protection steering group had been introduced, with two meetings held to date. This provided senior management oversight of procedures for multi-agency arrangements and monitoring provisions for prisoners who posed a risk to others, including children. This was supported by a public protection self-assessment tool and action plan.

6.26 Processes for identifying prisoners who posed a risk to the public had improved. Initial risk screening was now better coordinated, with all prisoners screened on arrival, and those meeting the threshold for potential monitoring were escalated to the head of OMU for further exploration and authorisation. A central database recorded all decisions, including those regarding prisoners identified for telephone and mail monitoring.

6.27 Monitoring arrangements were also better coordinated. The backlog of telephone monitoring was minimal and summaries of calls intercepted were communicated to the public protection unit in a timely manner. The post room was given a list of prisoners subject to mail monitoring.

6.28 At the time of the inspection, approximately 60 prisoners were subject to child contact restrictions and there was oversight of these arrangements. Authorisation forms were appropriately detailed and annual reviews of child contact restrictions assessed whether prisoners posed a continuing risk to children.

Categorisation and transfers

6.29 Around 205 prisoners at the establishment were category C. In the last 12 months, only seven prisoners had been recategorised from C to D.

6.30 Most of the categorisation reviews that had taken place in the previous 12 months had resulted in no change for prisoners. Reviews were also delayed in too many cases, sometimes for up to three months.

Interventions

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

6.31 Leaders were not informed about the treatment needs of their population. The process for conducting a needs analysis had started in April 2021, but had not been completed at the time of the inspection, some 10 months later.

6.32 There were no accredited interventions at either site. The lack of POM contact (see paragraph 6.13) and key work (see paragraph 6.19) meant that there was little one-to-one intervention to address offending behaviour. A small number of prisoners had benefited from non-accredited interventions from Spurgeons, the education team and the chaplaincy.

6.33 POMs had used the maturity screening assessment to identify younger prisoners who might benefit from the Choices and Changes offending behaviour resource pack (see Glossary), which had been delivered to a few prisoners in the past. Additionally, the OMU, in conjunction with Milton Keynes College, had developed a small selection of changing offending behaviour workbooks, but these had not yet been introduced.

6.34 There was some basic support for prisoners with employment needs. An information, advice and guidance (IAG) worker attended the prison three to four times weekly and all new arrivals, including remanded prisoners, were offered an IAG screening toolkit to complete. This was followed up with a personal learning plan, with priority given to prisoners within the last 10 months of their sentence. However, the initial IAG screenings were sent to prisoners to complete themselves in-cell, rather than face to face with a member of staff. As a result,

response levels were low (24–44%) and not all prisoners were able to create a personal learning plan to help their progress.

6.35 There had been only one release on temporary licence (ROTL) in the previous 12 months, despite the resettlement function of the category C unit. We were shown promising plans and good links being made with local employers to use ROTL to improve resettlement provision as restrictions eased.

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.

6.36 On average, 80 prisoners were released from the establishment each month. Following the reunification of probation services in June 2021, we found a mixed picture in terms of release planning.

6.37 The resettlement team saw new prisoners, including those on remand, within five days of arrival. We observed the team offering advice and guidance, including on how to maintain tenancy agreements and cancel community payments. Staff provided some support to prisoners approaching release, although details were often not settled until their last few days in the prison.

6.38 Leaders did not collate and review data on prisoner outcomes, such as sustainable accommodation and work on release. The limited data available indicated that a large number of prisoners were released without accommodation (23%), unemployed or on benefits (74%). However, the data were incomplete as not all releases were recorded, and the information was based on prisoners' self-declaration and was not verified.

Recommendation

6.39 **Prisoners eligible and approved for home detention curfew should be released on their eligibility date.**

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 1.39: Delivery of priorities set at the last inspection was slow, and the plan to deliver the basics of custody had not been executed well or delivered the results intended. Standards were not set sufficiently high, and leaders had become complacent about some poor outcomes.

Key recommendation: Leaders should ensure that the basics of custody are delivered consistently and to a high standard.
(To the governor)

7.2 Key concern 1.40: Staffing levels were not sufficient to deliver a decent regime and current recruitment did not keep pace with staff departures. Relationships between staff and prisoners inevitably suffered because of a lack of meaningful interaction and frustration caused by the inability to get the simplest tasks done. Fragilities within the management structure limited oversight, role modelling and support for staff.

Key recommendation: Staffing at all levels should be sufficient to deliver a full regime, support constructive relationships and facilitate leaders to carry out their line management duties.
(To HMPPS)

7.3 Key concern 1.41: Winchester remained one of the least safe prisons in the country. Incidents were not always investigated to help leaders gain a full understanding of the underlying causes of violence to enable them to devise a responsive strategy. Staff were unfamiliar with some key processes and the culture of the prison did not motivate good behaviour.

Key recommendation: A thorough analysis of the causes of violence should be used to devise a safety strategy that addresses deep-seated cultural issues to reduce the high levels of violence and make the prison safe.
(To the governor)

7.4 Key concern 1.42: Documentation to justify the use was force was often incomplete. Body-worn video cameras were not routinely operated during incidents, and recordings of incidents, both planned and spontaneous, were not always retained. Some incidents were not recorded through the HMPPS incident reporting system. Governance of the use of force was poor. As a result of these deficiencies, HMPPS could not be assured that all force used was proportionate, necessary and justified.

Key recommendation: Prison leaders should provide rigorous oversight of the use of force, ensuring appropriate accountability through accurate reporting, activating body-worn cameras and retaining footage as evidence and to inform learning.
(To the governor)

7.5 Key concern 1.43: Self-harm rates remained high in comparison with those at similar prisons, and the establishment was not making effective use of available data to understand the underlying causes of self-harm. There was insufficient quality assurance and inadequate peer support for prisoners who were in crisis.

Key recommendation: Data analysis should be used to understand the root causes of self-harm, and the results should inform an effective action plan to reduce incidents and support prisoners at times of crisis.
(To the governor)

7.6 Key concern 1.44: Too many prisoners on the local site lived in cold, poorly equipped and dirty cells. Many cells were overcrowded. The ‘decency policy’ was not being implemented, and staff and many prisoners had become desensitised to the poor conditions that many prisoners were held in. Access to basics, such as a daily shower, cleaning materials, clean bedding, clothing and stored property, was too often very poor.

Key recommendation: All prisoners should have access to the basics of custody, including in-cell furniture, daily showers, cleaning materials, clean bedding and clothing, and their own stored property.
(To the governor)

7.7 Key concern 1.45: The prison and health care staffing challenges were having a detrimental impact on the delivery of mental health and pharmacy services, as well as on access to clinics and secondary care. This resulted in delays for mental health assessment, limited access to a pharmacist and delays in treatment.

Key recommendation: The partnership board should assure itself that patient care is not compromised as a result of inadequate staffing; that there is appropriate support, training and clinical supervision of staff; and that delays in accessing services are prioritised, and that, where necessary, services are applying duty of candour where deficits are identified.
(To the health partnership board)

7.8 Key concern 1.46: Prisoners had insufficient time out of cell and access to purposeful activity. Many prisoners on the local site spent about 23 hours a day locked in their cells, and some even longer. There was insufficient activity across both sites, which led to frustration and a detrimental impact on mental and physical well-being.

Key recommendation: All prisoners should have adequate time out of cell to conduct domestic tasks, engage in purposeful activities and socialise with peers.
(To the governor and HMPPS)

7.9 Key concern 1.47: Leaders and managers had not considered the quality of teaching and assessment, and had focused too much on compliance and processes. They did not help teachers or instructors to improve their teaching and training practices effectively.

Key recommendation: Leaders should make sure that they evaluate fully the quality of teaching and assessment. They should identify and implement actions that will improve teachers' and instructors' teaching practices.
(To the governor)

7.10 Key concern 1.48: Leaders had not taken sufficient, or effective, actions to make sure that prisoners attended their education and work activities, and there were too few spaces for the size of the population. Too many prisoners had their progress disrupted by their inability to attend activities and their frequent lateness because of substantial delays to the regime.

Key recommendation: Leaders should maximise prisoners' opportunities to access education and work, and enable them to attend their allocated activities on time.
(To the governor)

7.11 Key concern 1.49: Leaders prioritised a minority of the population for face-to-face inductions, allocation to activities and access to advice and guidance. They did not understand the needs, experience or aspirations of most of the population.

Key recommendation: Leaders should allocate prisoners to activities fairly, taking into account their needs and aspirations, and give them equal access to essential services, including induction and careers advice and guidance.
(To the governor)

7.12 Key concern 1.50: Leaders and managers did not make sure that teachers and instructors provided prisoners who had a learning difficulty or disability (LDD), or for whom English was not their first language, with the support they needed to succeed. Too few prisoners with known LDD or English for speakers of other languages (ESOL) needs developed the skills and knowledge they needed for their next steps.

Key recommendation: Leaders should make sure that teachers and instructors adapt their teaching practices to take account of prisoners' known learning needs. Support staff should make sure that they identify appropriate support strategies, which they share with teachers and instructors, so that prisoners make good

progress in their learning and training.
(To the governor)

Recommendations

7.13 Recommendation 3.7: All prisoners should be provided with basic services, such as access to showers and telephone calls, on their first day and an adequate induction programme in their first few days at the prison.
(To the governor)

7.14 Recommendation 3.16: Senior leaders and managers should create an environment that motivates, rewards and promotes positive behaviour.
(To the governor)

7.15 Recommendation 3.26: All segregation cells should be adequately equipped and include cell furniture as standard.
(To the governor)

7.16 Recommendation 3.34: The prison should take robust action to reduce the availability of illicit drugs and alcohol.
(To the governor)

7.17 Recommendation 3.42: Safer custody staff should be given sufficient time to provide essential care for those at risk of self-harm.
(To the governor)

7.18 Recommendation 3.46: All staff should receive sufficient guidance on local safeguarding reporting procedures that includes how to identify and protect any prisoner whose vulnerability places them at risk of harm, abuse or neglect. (Repeated recommendation 1.56)
(To the governor)

7.19 Recommendation 4.13: Cell bells should be answered within five minutes, with any delays being investigated and remedied.
(To the governor)

7.20 Recommendation 4.43: The specific requirements of prisoners with protected characteristics should be identified and met. (Repeated recommendation S49)
(To the governor)

7.21 Recommendation 4.57: All clinical areas should be fully compliant with infection control guidelines. (Repeated recommendation 2.55)
(To the governor)

7.22 Recommendation 4.81: Prisoners requiring treatment in hospital under the Mental Health Act should be transferred within the timescales established by the Department of Health. (Repeated recommendation 2.75)
(To the health partnership board)

7.23 Recommendation 4.82: Prisoners' mental health needs should be appropriately identified and progressed on arrival as a priority.
(To the governor and head of health care)

7.24 Recommendation 4.98: Interim pharmacy arrangement should be in place to ensure robust governance and oversight of the service, prescribing and monitoring of medicines, and supervision of technicians.
(To the health partnership board)

7.25 Recommendation (6.23): The reducing reoffending strategy should be based on a comprehensive needs analysis of the different types of prisoner held at the establishment, and be supported by a detailed action plan which is regularly reviewed to demonstrate the progress made.
(To the governor)

7.26 Recommendation 6.39: Prisoners eligible and approved for home detention curfew should be released on their eligibility date.
(To the governor)

Section 8 Progress on recommendations from the last full inspection report

Recommendations from the last full inspection

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

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2019, there had been some improvements to how prisoners were received and inducted. Levels of violence had increased and were high at the local site, although few incidents were serious. Violence on the category C site was rare. The slow implementation of challenge, support and intervention plans (CSIPs) and a new incentive and earned privileges (IEP) scheme meant behaviour management was not yet effective. Use of force was very high and special accommodation was used too frequently. The segregation unit remained bleak. Security arrangements were broadly proportionate, and the level of drug use was similar to other establishments. There had been seven self-inflicted deaths since the previous inspection. Levels of self-harm had increased and were exceptionally high and the prison's response had been inadequate. Outcomes for prisoners were poor at the local site and reasonably good at the category C site against this healthy prison test.

Key recommendations

All new arrivals should be subject to rigorous assessment to ensure that any identified risks are managed effectively and appropriate support is provided. (S42)
Not achieved

Robust behaviour management strategies should be implemented and embedded to reduce levels of violence. (S43)
Not achieved

Oversight of special accommodation should ensure that its use is always justified and approved at the appropriate level. (S44)
Achieved

The segregation unit should be replaced with a modern, fit-for-purpose facility. (S45)
Partially achieved

A robust local strategy to reduce the levels of suicide and self-harm should be introduced. (S46)
Partially achieved

Recommendations

Managers should do more to create an environment and culture that motivates, rewards and promotes positive behaviour. (1.20)
Not achieved

Body-worn camera footage should be available and scrutinised to ensure that the use of force is justified and proportionate (1.29)
Not achieved

Suspicion based searches and drug testing should be carried out as required and the outcomes monitored. (1.42)
Not achieved

All staff should receive sufficient guidance on local safeguarding reporting procedures that include how to identify and protect any prisoner whose vulnerability places them at risk of harm, abuse or neglect. (1.56)
Not achieved (recommendation repeated, 3.47)

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2019, staff–prisoner relationships were reasonably good and key work was developing very well. Living conditions at the local site remained poor and too many prisoners could not shower every day. However, prisoners could keep their cells clean. Conditions were better at the category C site. Consultation through the prisoner council was improving. The formal application system worked well, but there were weaknesses in the complaints system. Strategic management of equality was beginning to improve, but support for prisoners with protected characteristics remained weak. Food was reasonable. The chaplaincy provided prisoners with good spiritual and pastoral care. Health provision was reasonably good, but the physical environment of the inpatient unit was impoverished. Outcomes for prisoners were not sufficiently good at the local site and reasonably good at the category C site against this healthy prison test

Key recommendations

Cells should be adequately equipped and suitable for the number of prisoners located in them. (S47)
Not achieved

Cell bells should be answered within five minutes. (S48)
Not achieved

The specific requirements of prisoners with protected characteristics should be identified and met. (S49)
Not achieved (recommendation repeated, 4.43)

An improvement plan should be developed that ensures the inpatient environment provides good care by delivering a coordinated therapeutic regime with access to a decent and enabling physical environment. (S50)
Not achieved

Recommendations

Staff should address prisoners by their first name or by their title followed by their surname. (2.5)
Not achieved

Responses to complaints should be based on a thorough investigation to which the prisoner has a meaningful opportunity to contribute. (2.25)
Achieved

All prisoners should be seen or be given the option to be seen by a prison chaplain before their release. (2.46)
Achieved

All clinical areas should be fully compliant with infection control guidelines. (2.55)
Not achieved (recommendation repeated, 4.57)

Access to sexual health services should be improved and barrier protection and related health advice should be available to prisoners to prevent sexually transmitted infections. (2.59)
Achieved

Prisoners with long-term health conditions should be promptly identified and receive regular reviews, informed by an evidence-based care plan. (2.68)
Achieved

Prisoners requiring treatment in hospital under the Mental Health Act should be transferred within the timescales established by NHS England and NHS Improvement. (2.75)
Not achieved (recommendation repeated, 4.81)

Officers should manage and supervise all medicine queues adequately, to protect patient confidentiality and prevent bullying and diversion. (2.88)
Achieved

Purposeful activity

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

At the last inspection, in 2019, time out of cell remained inadequate for prisoners on the local site and too few prisoners across both sites were in purposeful activity during the core day. The library was good, but access was poor. Access to the gym was better for category C prisoners than for those on the local site. Overall education, skills and work were ineffective. Leadership and management had significantly deteriorated since the previous inspection and was poor. The prison provided sufficient activity places for the large majority of the population at the category C site, but not enough at the local site. The quality of teaching and learning required improvement. Attendance was low and punctuality was poor. Achievements in English and mathematics continued to be low. Outcomes for prisoners were poor at both the local site and the category C site against this healthy prison test.

Key recommendations

Prisoners should have 10 hours out of their cells during the core day to provide sufficient time to work or attend education and to complete domestic activities such as showering, cleaning their cells and spending some time in the open air. (S51)
Not achieved

The education, skills and work provision should be effectively managed. Managers should analyse and use data to evaluate performance to inform decisions about the provision, so that purposeful activities can be created to meet the needs of all prisoners across both sites. (S52)
Not achieved

Attendance and punctuality at education, skills and work should be improved. Prisoners' induction should provide them with the necessary careers information, advice and guidance. The vocational training and work provided should enable prisoners to develop good skills and improve their chances of positive rehabilitation. (S53)
Not achieved

Prison leaders and managers must ensure that sufficient staff are trained and experienced enough to support prisoners with specific and/or additional learning needs and that mentors receive training to improve their mentoring skills. Trainers and instructors should promote English and mathematics during work activities more effectively. (S54)
Not achieved

Accredited and non-accredited outcomes for learners should be appropriately tracked and monitored, so that steps can be taken to ensure all achieve as well as they can, with a clear focus on improving their English and mathematics skills. (S55)
Not achieved

Recommendations

Leaders and managers should use the pay policy to encourage prisoners to attend education. (3.18)
Achieved

The IEP system should be applied consistently. (3.19)
Not 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 2019, children and families work was good and the prison had some innovative provision to help prisoners maintain family ties. Rehabilitative work was good but uncoordinated and the reducing reoffending strategy meeting did not drive rehabilitative services. The category C site was not used effectively as a resettlement unit. Most prisoners had a sentence plan to help them progress and levels of contact between prisoners and offender supervisors were adequate. Prison offender supervisors were not adequately trained to manage high risk cases. A third of eligible prisoners were still in custody beyond their home detention curfew (HDC) eligibility date. Public protection procedures were inadequate. Release planning was in place but about half of prisoners were released without settled accommodation. Outcomes for prisoners were not sufficiently good at the local site or at the category C site against this healthy prison test.

Key recommendations

The prison should ensure all risk management processes are working effectively to provide safe and purposeful release planning. (S56)
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
Deborah Butler	Team leader
Ian Dickens	Inspector
Lindsay Jones	Inspector
Ali McGinley	Inspector
David Owens	Inspector
Jade Richards	Inspector
Paul Rowlands	Inspector
Nadia Syed	Inspector
Charlotte Betts	Researcher
Rachel Duncan	Researcher
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Sophie Riley	Researcher
Alec Martin	Researcher
Isabella Raucii	Researcher
Sarah Goodwin	Lead health and social care inspector
Tania Osbourne	Health and social care inspector
Noor Mohammed	Pharmacist
Lynda Day	Care Quality Commission inspector
Rebecca Perry	Ofsted inspector
Carolyn Brownsea	Ofsted inspector
Rebecca Jennings	Ofsted inspector
Steve Lambert	Ofsted inspector
Martyn Griffiths	Offender management inspector

Appendix II Glossary

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/

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.

Choices and Changes programme
An HMPPS resource pack for key workers or prison offender managers to use in one-to-one sessions with young adults who have been identified as having low psychosocial maturity. The exercises in the pack aim to encourage engagement and help young adults to develop their maturity.

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

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

Offender management in custody (OMiC)
The Offender Management in Custody (OMiC) model, being rolled out across the closed male prison estate, entails prison officers undertaking key work sessions with prisoners (implemented during 2018–19) and case management, which established the role of the prison offender manager (POM) from 1 October 2019. On 31 March 2021, a specific OMiC model for male open prisons, which does not include key work, was rolled out.

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

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

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

REAL (relationships, environment, activities and leadership) strategy
The strategy identifies these four areas as priorities for the prison. The emphasis is on making sure the basics of custody are in place. In the present inspection, the governor had added two more elements: ‘safety’ and ‘recovery’.

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

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

Secure video calls
A system commissioned by HM Prison and Probation Service (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.

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 Winchester 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

Practice Plus Group Health and Rehabilitation Services Limited.

Location

HMP Winchester

Location ID

1-9090253242

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 18: Staffing 2(a)

The intention of this regulation is to make sure that providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements described in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How the regulation was not being met

Persons employed by the service provider in the provision of a regulated activity must—

a. receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

- Staff access to clinical and managerial supervision was inconsistent: The provision and uptake of clinical and managerial supervision was inconsistent and was not delivered in line with the organisation's supervision policy. Staff that we spoke to said they had not had regular supervision.

Regulation 17: Good Governance 2 (b)

The intention of this regulation is to make sure that providers have systems and processes that ensure that they are able to meet other requirements in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulations 4 to 20A).

How the regulation was not being met

To meet this regulation; providers must have effective governance, including assurance and auditing systems or processes.

b. The systems and processes must also assess, monitor and mitigate any risks relating the health, safety and welfare of people using services and others.

- Systems and processes did not always ensure onward referrals were made as required following the identification of need within the reception screening. Managers did not monitor look at the list of referrals to ensure all needs were addressed. We reviewed seven patient records and found that their reception referral to the mental health team was not followed up. This meant new patients arriving into the prison with identified needs, were not always seen promptly.

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 [delete as required]:

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.

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