



Report on an independent review of progress at

HMP Wandsworth

by HM Chief Inspector of Prisons

19–22 June 2022



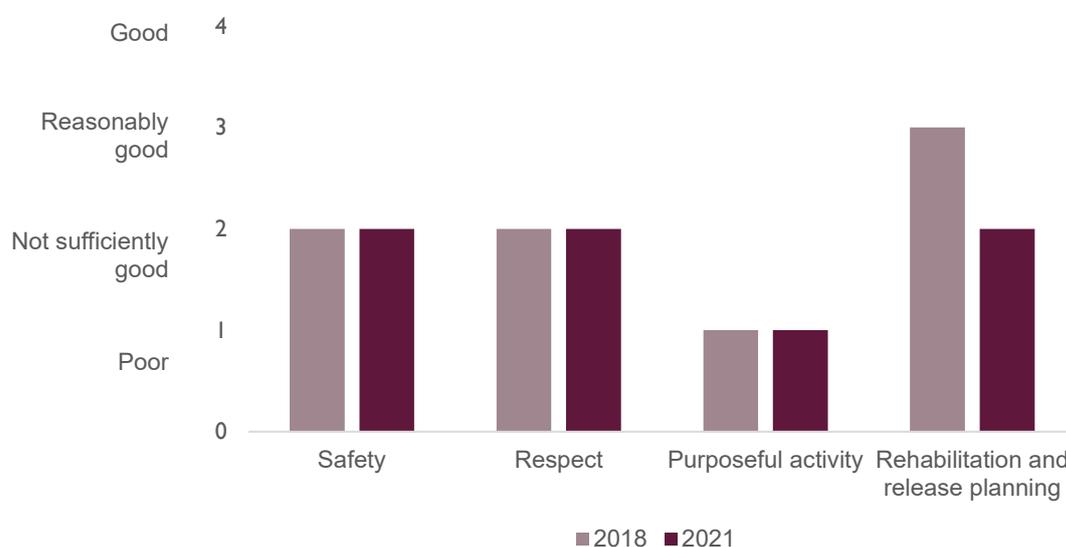
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Section 1 Chief Inspector's summary

- 1.1 HMP Wandsworth, an inner-city male reception prison serving the London courts, is one of the oldest and most famous prisons in the country. It is a large, complex establishment with a transient population of more than 1,400 adult and young adult prisoners, ranging from those recently remanded to others serving significant sentences.
- 1.2 At our previous inspections of HMP Wandsworth in 2018 and 2021, we made the following judgements about outcomes for prisoners.

Figure 1: HMP Wandsworth healthy prison outcomes in 2018 and 2021



- 1.3 At this independent review of progress, we assessed progress against 12 key recommendations including three identified by Ofsted. Overall, progress was mixed: we found it was reasonable or better in six of the 12 areas reviewed.
- 1.4 It was good to see substantial improvements in the governance of use of force. Leaders had established robust oversight of incidents and took appropriate action when they identified poor practice by staff. In addition, support for foreign national prisoners, who made up 45% of the population, had been transformed. Home Office staff were now on site running regular wing surgeries and prisoners received good support from Catch 22 and BEST.
- 1.5 In education, assessments of English and mathematics now took place on arrival and the number of accredited qualifications offered had improved in classroom-based subjects. However, accredited qualifications were more limited in vocational training.
- 1.6 The new mental health provider had also made progress in addressing the widespread deficiencies identified at the inspection. While the

service remained frail, staffing levels were improving and there was now better identification of the mental health needs of new arrivals.

- 1.7 Less positively, violence had increased since the time of the inspection. While investigations of violent incidents and oversight of plans to challenge perpetrators and support victims of violence had improved, many residential officers were unclear about their role in plans to reduce violence and lacked confidence in challenging poor behaviour on the wings.
- 1.8 The prison remained very overcrowded, with many prisoners living in very poor conditions. Several capital projects were in progress which would deliver improvements, but many of these were behind schedule and, even when complete, would not resolve all the deficiencies at Wandsworth. It was concerning that staff and managers were not doing everything they could to notice or address the issues that were in their control. Prisoners were moved into dirty, graffiti covered cells, some of which had no windows. Cleaning cupboards continued to be in disarray and there were large amounts of rubbish in exercise yards attracting vermin. We found that there was no credible plan to make sustainable improvements across the wings.
- 1.9 Despite improvements, time out of cell remained too limited. There was not enough activity for the population and this was compounded by managers not filling all available activity spaces and poor attendance in education. As a result, more than half the population was unemployed and these prisoners were locked up for 22 hours a day.
- 1.10 Support for prisoners who needed help to find accommodation on release was very poor. There was little assessment of need and no service for remand prisoners who made up the overwhelming majority of the population. According to national data, less than half the prisoners leaving Wandsworth had a place to stay on the night of their release.
- 1.11 Since the previous inspection, the governor had left the establishment and a substantive governor was due to start the week after our review of progress. The interim governor had made reasonable progress in improving oversight and long-term planning. However, the problem of the very high rates of non-effective staff was unchanged since the inspection. Without progress in this area, outcomes at Wandsworth will continue to struggle, making it a clear priority for the incoming governor.

Charlie Taylor
HM Chief Inspector of Prisons
June 2022

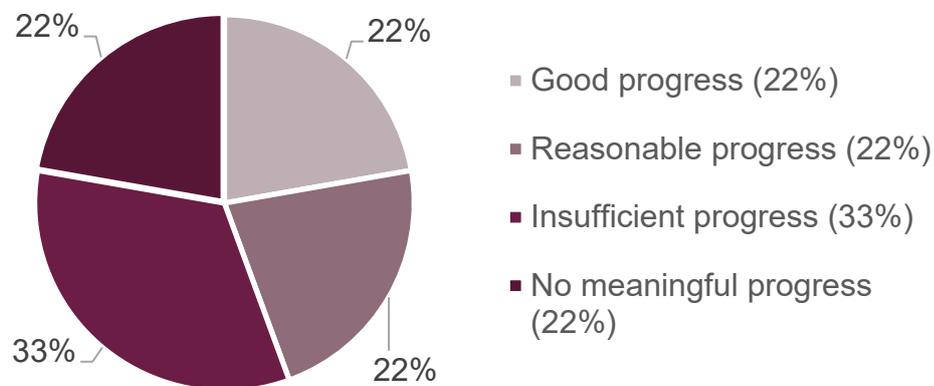
Section 2 Key findings

2.1 At this IRP visit, we followed up nine recommendations from our most recent inspection in September 2021 and Ofsted followed up three themes based on their latest inspection of the prison.

2.2 HMI Prisons judged that there was good progress in two recommendations, reasonable progress in two recommendations, insufficient progress in three recommendations and no meaningful progress in two recommendations.

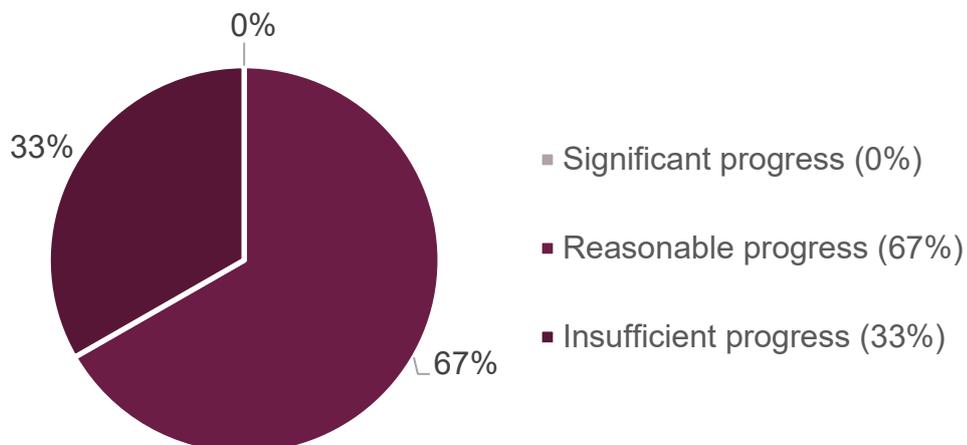
Figure 2: Progress on HMI Prisons recommendations from 2021 inspection (n=9)

This pie chart excludes any recommendations that were followed up as part of a theme within Ofsted's concurrent prison monitoring visit.



2.3 Ofsted judged that there was significant progress in two themes and insufficient progress in one theme.

Figure 3: Progress on Ofsted themes from 2021 inspection (n=3).



Notable positive practice

- 2.4 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.
- 2.5 Inspectors found one example of notable positive practice during this independent review of progress.
- 2.6 Every use of force was viewed by the coordinator who referred any that met a set criterion or were of concern to a weekly use of force scrutiny meeting. This enabled leaders to be sure that every use of force was justified and proportionate. Leaders had identified that restraints of prisoners under 25 were disproportionately high and viewed every restraint for this group. (See paragraph 3.14)

Section 3 Progress against the key concerns and recommendations and Ofsted themes

The following provides a brief description of our findings in relation to each recommendation followed up from the full inspection in 2021. The reference numbers at the end of each recommendation refer to the paragraph location in the full inspection report.

Leadership and management

Concern: Although leaders were making good use of data to measure daily and weekly progress, governance arrangements were not sufficient to make sure that longer-term plans, targets and monitoring were taking place in a number of important areas such as violence reduction, use of force, key work, safety and equality and diversity.

Recommendation: Prison leaders need to develop longer-term plans for improving the prison against their priorities. The governor and his team should introduce robust governance arrangements to give them assurance that plans are being followed, that work is taking place on time, that there are clear lines of accountability, that progress is monitored and that there is a process for reviewing plans. (1.44)

- 3.1 A consolidated action plan had been put together drawing actions from several key areas around the prison. The governor met each functional head once a month and reviewed progress against the action plan and several other areas for which the manager was responsible.
- 3.2 These meetings were comprehensive and the governor had developed a support system that had improved data integrity and collated information accurately from across departments. This was used to check progress and address areas of concern, for example regular checks were carried out on ACCT documents (assessment, care in custody and teamwork case management of prisoners at risk of suicide or self-harm) and leaders quickly identified when these checks were missed and notified the appropriate staff. This procedure had recently been complemented by the introduction of a performance assurance meeting at which all performance data were shared with the leadership team.
- 3.3 The governor had identified as a key priority staff retention and making sure that staff were able to provide the most effective service. At the time of our visit, about 44% of staff were absent from work or unable to carry out their normal duties (termed 'non-effective' by HMPPS).
- 3.4 Mentors were now available for new officers and a new performance management policy had been developed, which had been communicated to middle managers at an away day and through a programme of performance management training. Wandsworth was

also now a pilot site for structured supervision, which would benefit about half the front-line staff, with an increased emphasis on well-being and reflective practice. It was too early to assess the impact of these measures.

- 3.5 The oversight of standards and living conditions for prisoners on the wings remained poor, which was disappointing. Some cells were in poor condition, we observed a lot of graffiti, litter and dirt remained inside and outside the wings and the built environment was in disrepair in places. Leaders had not been able to deliver substantial improvements to standards on the wings since our last inspection.



Cell in poor condition

- 3.6 We considered that the prison had made reasonable progress against this recommendation.

Encouraging positive behaviour

Concern: Over half the respondents to our survey said that they had felt unsafe at some point during their time at Wandsworth. There was no formal support for victims. Violence was increasing and the number of assaults on staff was high. The management of perpetrators of violence was weak, too many investigations into incidents were not thorough enough, and there was no embedded violence reduction strategy or action plan.

Recommendation: There should be a prison-wide approach to reducing violence and making prisoners feel safe. This should include setting targets for set periods, monitoring progress and reviewing and, where necessary, amending plans. (1.45)

- 3.7 Levels of violence among prisoners and against staff remained high and had increased since our last inspection. During the previous six months, serious assaults had doubled compared to the six months before the last inspection. Leaders attributed this to the change in roll for Wandsworth which now accepted prisoners from a larger number of courts in the Greater London area. They felt this had increased the number of gang-related issues that staff had to manage and prisoners now spent more time out of cell which allowed more opportunity for these tensions to develop.
- 3.8 Leaders had responded by developing several strategies designed to reduce the level of violence and improve prisoners' perceptions of safety. These included violence reduction, self-isolation and safety strategies. A violence reduction action plan had been created but this needed further development and it was too early to judge its impact on levels of violence.
- 3.9 The weekly safety intervention meeting was well attended and now included support for victims of violence as well as perpetrators through care, support and intervention plans (CSIPs). Prisoners we spoke to who were victims supported by CSIPs were positive about the help they had received from staff. All violent incidents were now referred for investigation.
- 3.10 However, CSIPs were not fully embedded and we found staff on some wings who were unaware of what they were or which prisoners had a CSIP. Prisoners on CSIPs on these wings said they did not feel supported. Leaders had identified this and had developed innovative solutions such as short videos about CSIPs which were sent to all staff.
- 3.11 Other associated policies such as the incentives scheme had been rewritten following consultation with prisoners. Rewards were now more meaningful and special consideration was given to younger prisoners to encourage them to behave well, which was good.
- 3.12 We considered that the prison had made insufficient progress against this recommendation.

Use of force

Concern: The use of force was high and there were no formal governance meetings. Staff involved in incidents did not always record de-escalation techniques or switch on body-worn cameras early enough to provide sufficient scrutiny. Not all incidents involving the use of batons and PAVA incapacitant spray were investigated by senior managers and too much use of force documentation was missing.

Recommendation: Leaders should make sure that body-worn cameras are switched on at the beginning of any incident. There should be regular and effective senior management scrutiny and oversight of the use of force, including deployment of batons and PAVA, to make sure that force used is always justified and proportionate. (1.46)

- 3.13 The number of times force had been used against prisoners had increased since our last inspection and was high. Leaders had identified that not all force had previously been reported and had developed rigorous systems to make sure that use of force data were now accurate.
- 3.14 There were now robust systems of governance to make sure that force was necessary and proportionate. Incidents that did not meet these criteria were investigated immediately as were incidents involving injuries or complaints. Leaders had identified that force was used disproportionately against prisoners under the age of 25 and these prisoners were also included. A dedicated use of force coordinator now reviewed all incidents and referred those that did not meet the criteria to the weekly use of force meeting and for review by a panel.
- 3.15 The de-escalation of some incidents by staff remained a concern and a training package had been developed and was being delivered to all staff.
- 3.16 Only 77 body-worn video cameras were available for staff which was not enough and prevented all staff from drawing a camera at the start of duty. Despite this, the number of cameras drawn each day had improved since our last inspection.
- 3.17 The full-time use of force coordinator was available to help staff improve the quality of their reports and there had been some improvement. The number of outstanding reports had reduced but at the time of our visit 65 reports were outstanding, which was too many.
- 3.18 We considered that the prison had made good progress against this recommendation.

Daily life

Concern: Wandsworth remained one of the most overcrowded prisons in the country with most prisoners sharing a cell built for one. The shower areas on Trinity were poor. The physical environment in the mental health inpatient unit was unacceptable, did not meet infection control standards and had ligature points that had not been remedied to reduce the risk to patients. The control of vermin needed greater focus, including measures to prevent food waste and rubbish being thrown from cell windows.

Recommendation: All living conditions, including the inpatient unit and Trinity unit, should be improved to safe and decent standards(1.47)

- 3.19 Most prisoners continued to live in overcrowded wings and living conditions remained very poor. A programme of investment across the prison only addressed some areas of need and many projects were delayed. It was positive that leaders had taken action to refurbish Trinity (G, H and K wings) and G wing was empty at the time of our visit. This investment would renovate and increase the capacity of showers, although this was only estimated to be completed by 2025. In the interim, prisoners on Trinity continued to shower in squalid conditions.



Poor living conditions



Showers on Trinity (above and right) and a poster about showers

3.20 Many staff did not notice or challenge poor standards on residential units where we observed broken furniture, messy wing offices, broken windows and cells with graffiti. Prisoners could only wash their clothes once every two weeks and prison-issue kit often ran short. Rooms containing cleaning equipment were disorganised and dirty, there were piles of litter in the grounds and inside wings, and bedsheets were being used to stop bird excrement falling through the netting. Some steps had been taken to control vermin, but rubbish continued to be thrown from cell windows which perpetuated the problem.



Rubbish thrown from cell windows

- 3.21 There was no plan to support front-line staff to raise standards and no robust assurance procedure to satisfy leaders that a respectful living environment was being maintained. Responsibility for the living environment was held by a combination of residential governors, the Ministry of Justice projects team and the in-house facilities management team. Oversight of the environment as a whole was weak and needed better coordination.
- 3.22 The living conditions for mentally unwell patients in the inpatient unit did not meet infection prevention and control standards. Facilities management and oversight of cleaning were poor. Six of the 12 cells in the mental health unit were being refurbished which was positive. Two of the remaining cells had recently been damaged leaving only four usable cells.
- 3.23 Investment had been secured for the Addison mental health inpatient unit. Some cells were being renovated to a good standard, but the remaining cells and facilities were still poor. They were non-compliant with infection control standards and some ligature points still had not been remedied.
- 3.24 We considered that the prison had made no meaningful progress against this recommendation

Protected characteristics

Concern: There was insufficient support for the many foreign national prisoners held at Wandsworth. Home Office immigration staff had only recently returned to the prison, face-to-face contact was limited, and wing surgeries were still suspended. Legal documents were often served too late, and prisoners and detainees spent far too long in prison with their cases unresolved.

Recommendation: Foreign national prisoners and detainees should have their cases reviewed promptly and have timely access to information, help and face-to-face support (1.48)

- 3.25 The provision for foreign national prisoners and detainees had improved since our last inspection. There had been a considerable reduction in detainees held under immigration powers beyond the end of their sentence.
- 3.26 The immigration officers were operating full time at the prison and were seeing prisoners face to face. General appointments had been introduced in February 2022 in legal visits and almost 300 appointments had taken place since then. Wing surgeries were now held on all residential units.
- 3.27 Catch 22, which provided support for foreign nationals, was now well established. Foreign national prisoners were seen on induction and offered one-to-one support throughout their time at Wandsworth. BEST, a charity befriending and supporting foreign national prisoners in Wandsworth, had continued to provide valuable support.
- 3.28 Oversight of foreign national prisoners had also improved, with a monthly meeting involving different departments and agencies. Prisoners that were held on IS91 (authority to detain notification) were discussed at these meetings, information was shared and work coordinated to drive improvements for foreign national prisoners.
- 3.29 We considered that the prison had made good progress against this recommendation.

Strategy, clinical governance and partnerships

Concern: The lack of primary mental health and inpatient staff resulted in patients not having their mental health needs met in a safe or timely manner. This was creating significant risks affecting the monitoring of referrals, assessments taking place within agreed timescales and ensuring that the outcome of assessments was fully documented.

Recommendation: The prison should work with the local delivery board, in conjunction with NHS England and Improvement, to make sure there are sufficient staff to meet the needs of patients with mental health problems safely. (1.49)

- 3.30 The new health provider had improved access to mental health and care services since taking over on 1 April 2022. They were also providing good governance to identify and manage risk.
- 3.31 Staffing levels had improved, a recruitment plan was in place and recruitment for most vacancies had been carried out. Interim cover was provided by temporary staff while recruitment checks were carried out and all shifts, including on the mental health in-patient unit, were

covered by a safe level of nursing staff. Permanent psychology services were available for prisoners with primary through to more complex needs. Until temporary staff were replaced with substantive employees, some areas of the service remained fragile.

- 3.32 A positive initiative had recently been introduced to make sure that all new arrivals were seen by a member of the mental health team within their first week. Referrals were triaged by the team each day and assessments were carried out in a timely manner, with no delays to patient care.
- 3.33 Patients on the mental health case load, including those on the inpatient unit, had comprehensive care plans. Record keeping was of a good quality and assessment outcomes were clearly documented.
- 3.34 Unwell prisoners had to be managed on the wings because of the lack of usable cells on the inpatient unit. These prisoners were managed effectively, but if a prisoner needed a bed urgently, they often had to be moved between health care and the segregation units.



Refurbished health care cell



Non-refurbished health care cell

- 3.35 Nursing care and oversight by psychiatrists in the inpatient unit were strong, with support from prison officers. However, there was no therapeutic regime and limited time out of cell despite access to a small garden and an area for prisoners to sit and socialise.
- 3.36 We considered that the prison had made reasonable progress against this recommendation.

Mental health care

Concern: Patients requiring transfer to secure mental health inpatient services continued to wait far too long for a bed. Only four of the 18 patients transferred to a mental health hospital under the Mental Health Act in the last six months had done so in fewer than 14 days. The remaining 14 patients waited from 15 to 226 days, which was unacceptable.

Recommendation: The prison should work with the local delivery board, in conjunction with NHS England and Improvement, to make sure that patients requiring a transfer under the Mental Health Act are transferred expeditiously and within the current transfer guidelines.

(1.50)

- 3.37 The transfer of prisoners under the Mental Health Act did not accord with national guidance, although the average waiting times to transfer had reduced in recent months which was promising.
- 3.38 The partnership board ensured that robust monitoring and oversight were delivered with the addition of a bespoke quality improvement lead for London. A transfer coordinator for Wandsworth was expected to be in post in July 2022.
- 3.39 At the time of our visit, eight patients were awaiting transfer or further assessment under the Mental Health Act, three of whom were in the inpatient unit and two in the segregation unit. Waiting times for transfer were between one and 101 days.
- 3.40 We considered that the prison had made insufficient progress against this recommendation.

Time out of cell

Concern: The daily regime remained far too limited, and most prisoners continued to spend more than 22 hours a day locked in their cells, with some denied access to the open air for days at a time. Opportunities to engage in purposeful activity remained very limited and too many prisoners were unemployed. Access to the library and the gym and education were poor.

Recommendation: Time out of cell should be improved, including a daily regime that provides at least an hour in the open air for all and access to work, PE, the library, education, training, or other constructive activities. (1.51)

- 3.41 Most prisoners were locked up for 22 hours a day which was too long. There had been some improvements since our last inspection, in particular prisoners now had access to the open air each day. Leaders strove to deliver this although, with a shortage of exercise yards, it was logistically difficult for some wings and access was frequently curtailed.



Broken bench in exercise yard

- 3.42 The regime was more limited on Fridays and weekends and on four of the previous eight weekends, at least one unit had experienced some level of reduced regime. Many prisoners did not have access to showers on Fridays, which had been particularly uncomfortable during the recent hot weather.
- 3.43 From June 2022 prisoners were able to move on free flow and attend purposeful activities. Leaders were incrementally increasing allocation to work and education but, at the time of our visit, not all the limited activity places were filled which was disappointing (see paragraph 3.47). Too many prisoners remained unemployed and locked in their cells for too long.
- 3.44 Gym staff were no longer cross deployed, which was positive, and most prisoners now had at least weekly access to the library and gym. Leaders were trying to recruit more gym staff and local data showed an exponential increase in prisoners' access to the gym. Pressures on staffing made the opportunity for both library and gym vulnerable to staff shortages.
- 3.45 We considered that the prison had made insufficient progress against this recommendation.

Education, skills and work



This part of the report is written by Ofsted inspectors. Ofsted's thematic approach reflects the monitoring visit methodology used for further education and skills providers. The themes set out the main areas for improvement in the prison's previous inspection report or progress monitoring visit letter.

Theme 1: What progress had leaders and managers made to ensure that they fully use all activity spaces, so that a high proportion of prisoners participate in purposeful activity?

- 3.46 Leaders and managers had not provided enough activity places to meet the needs of the population. Education, skills and work spaces were available for less than half the population and there were long waiting lists for many activities. Too many prisoners were waiting for English and English for speakers of other languages (ESOL) courses and many more wanted to complete the Construction Skills Certification Scheme (CSCS). As a result, too many prisoners were not able to develop the skills they needed for employment or training on release.
- 3.47 Leaders and managers had not ensured that the available activity places were sufficiently used. During our visit about a fifth of all places remained unfilled. In education, this rate was even higher. In mathematics and art, for example, only about half the available places were filled. Despite empty places in classes, prisoners remained on waiting lists. This limited the progress the prisoners could make during their short stays at the prison.
- 3.48 There were plans to increase the number of activity places. Before the end of the restricted regime in June 2022, education activities had been limited to English and mathematics lessons taught in the accommodation wings. Leaders and managers had recently started to reintroduce education and training in the specialist locations but the shortage of prison officers with relevant experience had limited the movement of prisoners from wings to activities.
- 3.49 Prisoners' attendance at education was not high enough. Attendance at English lessons was particularly low with only a handful of prisoners present. Only just over half the allocated prisoners attended their ESOL lessons. Some prisoners lacked motivation, others preferred to attend other activities such as gym, which managers had too often timetabled at the same time. Prisoners did not value enough the opportunity to develop their knowledge and skills through education.
- 3.50 Ofsted considered that the prison had made insufficient progress against this theme.

Theme 2: What progress had leaders and managers made to ensure that staff understand the prior knowledge of English and mathematics that prisoners have, so that they can place them on suitable courses?

- 3.51 Until recently, staff had not carried out an accurate assessment of all prisoners' previous knowledge of English and mathematics. During COVID restrictions, only those prisoners who studied English and mathematics in small groups on the wings undertook accurate assessments. In these cases, teachers used information from the assessments effectively to plan learning. However, the assessments completed by prisoners as part of an in-cell pack were not sufficiently accurate and staff did not have a good enough understanding of every prisoner's knowledge.
- 3.52 Actions to improve the accuracy of the English and mathematics assessment had started to have a positive impact. Since early June 2022, all assessments had taken place during supervised induction and staff used the prisoners' assessments effectively to place them on suitable courses.
- 3.53 Teachers used the information from initial assessments and completed further assessments of prisoners' abilities in English and mathematics to create useful individual learning plans and to plan the curriculum. Teachers planned the curriculum pathways effectively and made sure that prisoners had the necessary competency in English and mathematics for the pathway they studied. Teachers encouraged prisoners to complete higher levels of qualifications in English and mathematics alongside their other learning.
- 3.54 Teaching staff reflected English and mathematics learning in prisoners' vocational studies. They supported the development of English and mathematics skills by helping prisoners to realise the importance of these skills in any future career. Teachers worked with vocational staff, for example in catering, to determine which English and mathematics skills prisoners needed to develop to help them in their careers. However, this approach was not developed systematically in every subject to maximise the benefits for all prisoners.
- 3.55 Ofsted considered that the prison had made reasonable progress against this theme.

Theme 3: What progress had leaders and managers made to introduce accredited qualifications in a wider variety of subjects, so that prisoners gain qualifications that will help them in their future careers or with further study?

- 3.56 Leaders had been very effective in increasing the number of accredited qualifications available to prisoners in education. For example, at our last visit prisoners were only able to achieve accreditation in CSCS and food safety. Leaders had since introduced accreditation in English,

mathematics, dry lining, horticulture, multi-skills, Open University and distance learning, rail track and radio production. As a result, prisoners had a greater range of courses that better met their individual needs.

- 3.57 Leaders had made sure that the recently introduced curriculum pathways were appropriately linked to accredited qualifications. Prisoners could now achieve accredited qualifications from entry level two to level two across five distinct curriculum pathways. As a result, they were able to develop the skills they needed to gain employment on release.
- 3.58 The number of prisoners who had achieved a qualification in education had improved greatly since our previous visit. A high proportion of prisoners attending education had achieved qualifications in mathematics, English and catering at level one.
- 3.59 The wide range of qualifications now offered in education and vocational training enabled prisoners to progress from one level of learning to the next. Many prisoners had progressed by one level in English or mathematics since our previous visit.
- 3.60 Leaders had not been successful in increasing the number of accredited qualifications available to prisoners in industries. Qualifications were not available in waste management, laundry, sewing and mechanical maintenance, although leaders had introduced non-accredited awards in industries and prisoners had achieved many of these awards. In addition, leaders had established a partnership with Team Sport indoor kart maintenance and were working with Google to establish an application to support prisoners on release. However, there remained too few opportunities for prisoners to have their newly developed knowledge and skills in industries accredited by an external qualification.
- 3.61 Ofsted considered that the prison had made reasonable progress against this theme.

Release planning

Concern: Following unification of the Probation Service, the housing provider no longer supported prisoners on remand. This resulted in the large number of remand prisoners not being able to access support, for example to secure tenancies or deal with rent arrears.

Recommendation: Leaders should make sure that there is effective housing support for all prisoners, including those on remand. (1.52)

- 3.62 Housing support for prisoners on remand remained a considerable gap in services. Almost three-quarters of the population were on remand and there was no service to help prisoners to resolve housing issues.
- 3.63 Wandsworth had participated in the 'reducing reoffending accelerator project' to build relationships with housing providers for identified

release boroughs in London. At the time of our visit, this was having a limited impact.

- 3.64 Substantial staff shortages now prevented the housing and other resettlement needs of newly arrived prisoners from being assessed and not all prisoners received a resettlement plan before release. Even if a service was in place, there was no systematic route for referral for all prisoners.
- 3.65 No local data on accommodation outcomes were collected; HMPPS data showed that only 43% of prisoners released in the last six months had accommodation for their first night of release, which was similar to the last inspection.
- 3.66 We considered that the prison had made no meaningful progress against this recommendation.

Section 4 Summary of judgements

A list of the HMI Prisons recommendations and Ofsted themes followed up at this visit and the judgements made.

HMI Prisons recommendations

Prison leaders need to develop longer term plans for improving the prison against their priorities. The governor and his team should introduce robust governance arrangements to give them assurance that plans are being followed, that work is taking place on time, that there are clear lines of accountability, that progress is monitored and that there is a process for reviewing plans.

Reasonable progress

There should be a prison-wide approach to reducing violence and making prisoners feel safe. This should include setting targets for set periods, monitoring progress, and reviewing, and where necessary, amending plans.

Insufficient progress

Leaders should make sure that body-worn cameras are switched on at the beginning of any incident. There should be regular and effective senior management scrutiny and oversight of the use of force, including deployment of batons and PAVA, to make sure that force used is always justified and proportionate.

Good progress

All living conditions, including the inpatient unit and Trinity unit, should be improved to safe and decent standards.

No meaningful progress

Foreign national prisoners and detainees should have their cases reviewed promptly and have timely access to information, help and face-to-face support.

Good progress

The prison should work with the local delivery board, in conjunction with NHS England and Improvement, to make sure there are sufficient staff to meet the needs of patients with mental health problems safely.

Reasonable progress

The prison should work with the local delivery board, in conjunction with NHS England and Improvement, to make sure that patients requiring a transfer under the Mental Health Act are transferred expeditiously and within the current transfer guidelines.

Insufficient progress

Time out of cell should be improved, including a daily regime that provides at least an hour in the open air for all and access to work, PE, the library, education, training, or other constructive activities.

Insufficient progress

Leaders should make sure that there is effective housing support for all prisoners, including those on remand.

No meaningful progress

Ofsted themes

Leaders should ensure that they fully use all activity spaces, so that a high proportion of prisoners participate in purposeful activity.

Insufficient progress

Leaders should ensure that staff understand the prior knowledge of English and mathematics that prisoners have, so that they can place them on to suitable courses.

Reasonable progress

Leaders should introduce accredited qualifications in a wider variety of subjects, so that prisoners gain qualifications that will help them in their future careers or with further study.

Reasonable progress

Appendix I About this report

Her Majesty's Inspectorate of Prisons (HMI Prisons) is an independent, statutory organisation which reports on the treatment and conditions of those detained in prisons, young offender institutions, secure training centres, immigration detention facilities, police and court custody and military detention.

All visits carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees. HM Inspectorate of Prisons is one of several bodies making up the NPM in the UK.

Independent reviews of progress (IRPs) are designed to improve accountability to ministers about the progress prisons make towards achieving HM Inspectorate of Prisons' recommendations in between inspections. IRPs take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny and focus on a limited number of the recommendations made at the inspection. IRPs do not therefore result in assessments against our healthy prison tests. HM Inspectorate of Prisons' healthy prison tests are safety, respect, purposeful activity and rehabilitation and release planning. For more information see our website: <https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/>

The aims of IRPs are to:

- assess progress against selected key recommendations
- support improvement
- identify any emerging difficulties or lack of progress at an early stage
- assess the sufficiency of the leadership and management response to our main concerns at the full inspection.

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each recommendation we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in [MONTH, YEAR] for further detail on the original findings (available on our website at <https://www.justiceinspectorates.gov.uk/hmiprisons/>).

IRP methodology

IRPs are announced at least three months in advance and take place eight to 12 months after a full inspection. When we announce an IRP, we identify which recommendations we intend to follow up (usually no more than 15). Depending on the recommendations to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

During our three-day visit, we collect a range of evidence about the progress in implementing each selected recommendation. Sources of evidence include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

Each recommendation followed up by HMI Prisons during an IRP is given one of four progress judgements:

No meaningful progress

Managers had not yet formulated, resourced or begun to implement a realistic improvement plan for this recommendation.

Insufficient progress

Managers had begun to implement a realistic improvement strategy for this recommendation but the actions taken since our inspection had not yet resulted in sufficient evidence of progress (for example, better and embedded systems and processes).

Reasonable progress

Managers were implementing a realistic improvement strategy for this recommendation and there was evidence of progress (for example, better and embedded systems and processes) and/or early evidence of some improving outcomes for prisoners.

Good progress

Managers had implemented a realistic improvement strategy for this recommendation and had delivered a clear improvement in outcomes for prisoners.

When Ofsted attends an IRP its methodology replicates the monitoring visits conducted in further education and skills provision. Each theme followed up by Ofsted is given one of three progress judgements.

Insufficient progress

Progress has been either slow or insubstantial or both, and the demonstrable impact on learners has been negligible.

Reasonable progress

Action taken by the provider is already having a beneficial impact on learners and improvements are sustainable and are based on the provider's thorough quality assurance procedures.

Significant progress

Progress has been rapid and is already having considerable beneficial impact on learners.

Ofsted's approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook*, available at <https://www.gov.uk/government/publications/education-inspection-framework>.

Inspection team

This independent review of progress was carried out by:

Angus Jones	Team leader
David Foot	Inspector
Donna Ward	Inspector
Sumayyah Hassam	Inspector
Tania Osborne	Health and social care inspector
Dayni Turney	Care Quality Commission inspector
Bev Gray	Care Quality Commission inspector
Allan Shaw	Ofsted inspector
Shane Langthorne	Ofsted 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.justiceinspectors.gov.uk/hmiprison/about-our-inspections/>

Care Quality Commission (CQC)

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

Certified normal accommodation (CNA) and operational capacity

Baseline CNA is the sum total of all certified accommodation in an establishment except cells in segregation units, health care cells or rooms that are not routinely used to accommodate long stay patients. In-use CNA is baseline CNA less those places not available for immediate use, such as damaged cells, cells affected by building works, and cells taken out of use due to staff shortages. Operational capacity is the total number of prisoners that an establishment can hold without serious risk to good order, security and the proper running of the planned regime.

Challenge, support and intervention plan (CSIP)

Used by all adult prisons to manage those prisoners who are violent or pose a heightened risk of being violent. These prisoners are managed and supported on a plan with individualised targets and regular reviews. Not everyone who is violent is case managed on CSIP. Some prisons also use the CSIP framework to support victims of violence.

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.

Protected characteristics

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

Protection of adults at risk

Safeguarding duties apply to an adult who:

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

Recovery plan

Recovery plans are published by HMPPS and aim to ensure consistency in decision-making by governors, by setting out the requirements that must be met for prisons to move from the most restricted regime to the least as they ease COVID-19 restrictions. (<https://www.gov.uk/government/publications/covid-19-national-framework-for-prison-regimes-and-services>)

Secure video calls

A system commissioned by 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.

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This publication is available for download at: <http://www.justiceinspectrates.gov.uk/hmiprisons/>

Printed and published by:
Her Majesty's Inspectorate of Prisons
3rd floor
10 South Colonnade
Canary Wharf
London
E14 4PU
England

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