1.42 Leaders monitored how many prisoners were subject to the regime that had the shortest amount of time out of cell and took remedial action to reduce the time prisoners remained unemployed. (See paragraph 5.2.)

1.43 The rugby academy programme enabled prisoners to make contact with community sports teams in their home areas before their release. (See paragraph 5.14.)

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

3.11 The level of assaults on other prisoners was currently higher than at all but three of a comparator group of 25 category C prisons, with a rate of 199 per 1000 prisoners in the past year. The number of assaults fluctuated from month to month, but it had been increasing in 2022, although it remained lower than throughout 2019.

3.12 The rate of assaults on staff had declined since the last inspection, and was continuing to do so. There had been three serious assaults on staff in the last year.

3.13 About half of all violence was carried out by young adults. To date in 2022, 38% of all assaults had been carried out by under-21s (an age group making up 14% of the population), and 39% by prisoners aged 21-24. Promising work was under way to support young adults who were involved in violence (see paragraph 4.32).

3.14 In our survey, 27% said that they had felt unsafe at some point during their stay, which was lower than at the previous inspection (43%) and compared with similar prisons (40%). However, 66% of respondents said they had mental health problems, 19% of whom said they felt unsafe at the time of the inspection, compared with 2% who said they did not. There was insufficient provision for the relatively high number with neurodiverse conditions or mental health issues (see paragraph 4.68.)

3.15 The challenge, support and intervention plan (CSIP) system (see Glossary of terms) was better used than at the previous inspection. Thirty were being managed under a CSIP at the time of the inspection, and all had their cases reviewed at the weekly safety intervention meeting (SIM). The SIM was effective – a wide range of managers attended and they had a well-informed discussion about every individual, reviewing progress and agreeing action in each case. Prisoners at risk of causing harm to others or at risk of harm themselves and those self-isolating also received support through CSIPs.

3.16 Managers provided individual support to those whose cases were discussed at the SIM. For example, debt management support, led and delivered mainly by the head of safety, was offered. However, officers on the wings did not find that they could offer daily support through the CSIP process, partly because it was an online system. They said their access to IT was limited and the system was often unreliable or slow.

3.25 Recordings showed planned interventions were handled competently and calmly. Not all staff were up to date with their training, and a level of inexperience sometimes showed in incident scene management when there was unexpected violence in a communal area.

3.26 All use of force was reviewed – footage was compared with written records at a weekly panel led by a senior manager. Action followed as a result of the meetings and staff and managers received prompt feedback. A further monthly meeting, attended by a limited number of senior managers, but chaired by the governor or deputy governor, considered very detailed analyses of incidents and of a wide range of variables, including protected characteristics (see Glossary of terms). Participants were working purposefully to reduce the level of use of force.

3.27 In our survey, 75% of those who had been restrained in the previous six months said that someone had talked to them about it afterwards, better than at the last inspection (22%) and in comparable prisons (36%). A debriefing session with the prisoner was held and recorded after every incident involving force.

3.28 Body-worn cameras were used in only a third of instances of force, partly because of defective cameras, due to be replaced within the following year. There had been very little use of batons and there had been no use of special accommodation in the previous two years, while PAVA (an incapacitant spray) had only been used once.

Segregation

3.29 Segregation was used relatively infrequently – there had been 87 occupants in the previous 12 months. Stays were not unduly long, except in the case of one prisoner for whom segregation was justified. A special regime was in place for this man, who was able to undertake paid employment within the grounds of the unit.

3.30 In-cell facilities had improved considerably with the addition of electrical and TV sockets and in-cell phones, new furnishings and toilets, and upgraded cell windows.

3.31 A basic regime was offered and prisoners had sufficient time in the open air. There was a lack of input from education, library and gym staff, but flexible arrangements were made for certain prisoners to move between segregation and the normal prison location to manage specific risks.

3.32 Reintegration plans were in place for all segregated prisoners at the time of inspection, and they were always on a CSIP (see paragraph 3.15) so they received consistent support.

3.33 The was better internal scrutiny of segregation than at the last inspection – monthly review meetings considered data, including all individual cases, broken down by age, religion and ethnicity.

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.

3.34 Security arrangements were generally proportionate. Physical security had been modified by the removal of 15 internal gates, but prisoners' freedom to move around the prison was still more restricted than we often see in a category C prison. Strip-searching was now only carried out in response to intelligence.

3.35 The flow of intelligence was lower than at the last inspection, but it was still good. Information reports were analysed promptly, and action was carried out reliably. The amount of suspicion-based cell searching had been reduced by targeting prisoners on whom there were several pieces of intelligence; these had a 28% success rate.

3.36 The security department managed well the shifting profile of gangs, organised crime groups and local allegiances among the prisoner population, as well as more traditional risk factors. Communication between the security department and other staff was good, and officers around the prison were aware of current security concerns and priorities. Dorset police cooperated with security staff in certain prisoners' cases and regarding the active corruption prevention work.

3.37 In our survey, more prisoners (15%) said they had drug or alcohol problems on arrival than in comparable prisons (8%), but fewer (18%) said it was easy to get illicit drugs than the comparator (31%) and the last inspection (43%). Prisoners told us that it was difficult to get drugs. There was little recent evidence of psychoactive substances being brought in, although finds of alcohol had recently increased.

3.38 There was good cross-departmental cooperation on implementing the drug strategy (see paragraph 4.70). Random drug testing had resumed in the previous three months, but there was only a confirmed positive rate of 16% for May, and it was too early to draw conclusions.

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

3.39 There had been two self-inflicted deaths since the last inspection, and the Prisons and Probation Ombudsman recommendation on establishing an effective mental health service had still not been achieved (see paragraph 4.45).

3.40 Self-harm had been on a gradual upward trajectory over the past year. When comparing the last 12 months with the 12 months prior to our previous inspection, the recorded rate of self-harm had increased by 15% and it was among the highest compared with similar prisons. There had been 13 serious self-harm incidents in the previous year, which was relatively low. However, investigations had taken place into only two of them, which was not sufficient.

3.41 The safety strategy was generic and not underpinned by an analysis of data. The action plan, although up to date, was not informed by evidence or data analysis, nor did it outline an objective measure of progress.

3.42 Monthly strategic safety meetings undertook some good analysis on protected characteristics, leading to appropriate action, but they had not sufficiently interrogated some of the persistent trends in self-harm. Safety peer workers had begun to attend the safety meetings.

3.43 Debt had been identified as a key trigger for the high levels of self-harm, but not enough had been done to determine what other factors were behind the elevated rates. The head of safety ran a debt management scheme for individuals struggling with debt in the prison (see paragraph 3.16).

3.44 A good multidisciplinary approach was often taken to individual case management. The SIM was well attended by relevant stakeholders across the prison, who discussed selected prisoners with multiple complex needs (see paragraph 3.15). At these meetings, leaders regularly reviewed the employment status of prisoners on assessment, care in custody and teamwork (ACCT) case management documents for prisoners at risk of suicide or self-harm. They also flagged up all licence recalls nearing release, following lessons learned from previous self-inflicted deaths.

3.45 Thirteen prisoners were on an ACCT case management document during the inspection. Prisoners told us that ACCTs provided them with additional assurances and staff helped them, but most could not tell us

about any action or targets to help them reduce their likelihood of self-harming.

3.46 ACCT documentation was variable. Many care plans contained no information or very little, and there were often no meaningful targets. This undermined some of the subsequent case reviews, although they were thorough and detailed. Quality assurance had been introduced, but it was too early to assess its impact.

3.47 Use of constant supervision was high – it had been used on 56 occasions for 30 prisoners in the previous year. The average length of constant supervision was four days, but for some it lasted for weeks, the longest being 45 days. No prisoners had been in anti-ligature clothing in the previous year.

Constant supervision cell

3.48 In the previous six months, an average of 543 calls a month had been made to the Samaritans. Most of the 11 trained Listeners had been recruited recently, but those we spoke to said the safety team and the Samaritans supported them well. In our survey, 54% of prisoners said it was easy to speak to a Listener, better than in similar prisons (31%). There was no Listener suite, but leaders planned to refurbish a room for Listener use.

Protection of adults at risk (see Glossary of terms)

3.49 There was no direct link to the local adult safeguarding board. The governor of a nearby prison was nominated to the board and shared information, but it was not clear how well this was communicated. Staff, including managers, could not name a point of contact, although they

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 Our survey showed there had been an improvement in relationships between prisoners and staff; 77% of prisoners said that staff treated them with respect compared with 59% at the last inspection, while 75% said they had someone they could turn to if they had a problem (60% previously). In addition, 53% said they were treated as an individual compared with 36% at the last inspection.

4.2 Interactions we observed across the prison were friendly and supportive. We saw officers skilfully manage potentially difficult situations and challenge most low-level poor behaviour. Prisoners were positive about their dealings with staff, both on wings and in work areas.

4.3 Prisoners were well supervised, and we rarely saw officers in offices without good reason. However, staff told us that the limited unlocking time, coupled with conflict when locking prisoners up after relatively short periods, made it difficult for them to develop more meaningful relationships.

4.4 The key worker scheme (see Glossary of terms) was very slow to restart following the pandemic and had only recently seen an increase in the number of sessions. Different officers assigned to the task ran sessions targeted at priority cases, which made developing consistent support almost impossible. In our survey, only 44% of respondents said they had a named officer, compared with 67% last time and 70% at similar prisons.

Equality, diversity and faith

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

Strategic management

4.27 Oversight of equality work was good. The equality adviser coordinated the work of the department and had an action plan in place. A wide range of equality data was reviewed at the well-attended monthly diversity and inclusion meetings, identifying disproportionate outcomes for prisoners. However, the prison lacked an establishment-wide equality strategy so was not well placed to address issues needing a coordinated response. Leaders had identified the gap and were developing a strategy.

4.28 There were prisoner equality representatives on most wings. They had a good understanding of their role and responsibilities. Two representatives also participated in the monthly diversity and inclusion meeting.

4.29 Senior managers were assigned to lead work on different protected characteristics and consultation was being undertaken, mainly through forums. They were well facilitated, and prisoners' perspectives were noted in the minutes and points for action incorporated into the equality action plan.

4.30 The number of discrimination incident reporting forms (DIRFs) submitted had increased since our last inspection. A number of prisoners told us they had more confidence in the process than previously, which had been a factor in the higher numbers. It was positive that complaints judged to include a discrimination element were dealt with through the DIRF process.

4.31 In the previous year, some 26% of DIRFs had been upheld or partially upheld which is more than we often see. Quality assurance for all DIRFs was undertaken by the equality advisor, the deputy governor and members of the Zahid Mubarek Trust, a third sector organisation with relevant expertise. DIRFs that we reviewed had been well investigated and responses were courteous and comprehensive.

Protected characteristics

4.32 About 28% of prisoners in our survey were 25 or under, 14% of whom were under 21. Understanding and responding to the needs of younger prisoners and care leavers (a person aged 25 or under, who has been looked after by a local authority) had rightly been identified as a priority

4.44 There were vacancies in senior leadership roles and clinical leaders were working as part of the team to prioritise patient care, which detracted from the fulfilment of their management responsibilities. There were insufficient regular health care staff across many grades, which placed additional demands on existing staff and put patient safety at risk. Recruitment had been, and was, ongoing. Agency and temporary staff were used to help deliver essential care.

4.45 Clinical governance processes were managed well, and risks identified. Lessons learned from incidents and serious investigations were shared and any changes in practice that had been identified were implemented. Not all recommendations from Prisons and Probation Ombudsman investigations had been implemented, which was poor (see paragraph 3.39).

4.46 We observed conscientious staff who knew patients well. Clinical supervision had been maintained throughout the pandemic. Mandatory training for staff had fluctuated but a recent focus on it had started to improve completion rates, which was good and supported safe practice.

4.47 The recent infection control audit had identified issues needing to be addressed. This included the failure to secure sharps bins to the wall and we observed that this had not been rectified, which was poor.

4.48 Our survey showed that prisoners were more positive about the health provision than in similar prisons, which was reflected in the feedback we received from patients and prison staff during our visit. Patients were consulted through patient surveys, but there were no patient health forums.

4.49 Health care application and complaint forms were readily available on all wings. They were located close to the dedicated health care mailbox, which meant it was straightforward for patients to submit confidential complaints.

4.50 Responses to patient complaints were conducted face to face and in a timely manner. However, the written responses we looked at were of poor quality, and in some cases illegible, leaving us unable to determine whether the concerns raised had been addressed appropriately. There was no management oversight to assess responses. When we raised this issue, we were assured a new procedure would be implemented immediately.

4.51 The health care department was welcoming, an improvement since our last inspection. Patients were also seen on the wings and inspectors were happy that patient confidentiality was maintained.

4.52 Emergency medicines, oxygen and an automated external defibrillator were located within short distance of the dental surgery. However, emergency resuscitation equipment had not been checked in line with policy. The contents of bags included emergency medication that had

safety intervention meeting and at clinical complex case review meetings, which supported the prison in managing those most at risk.

4.66 The applications and allocations processes were not well structured, and too much responsibility was placed on the acting clinical lead nurse to oversee all aspects of the service. They were also required to hold substance misuse clinics and routinely undertake medicine administration.

4.67 Referrals were placed in the appointment diary. Many of these were triaged without the patient being seen, which meant prisoners with hidden needs and risks could have been missed. Most were referred to the primary care team to access support that was not currently available. Patients identified as requiring a face-to-face assessment were seen within five days for a routine appointment and on the same day if urgent, but arrangements were too dependent on which staff were available on any given day. Despite this, clinical records indicated assessments were thorough, but most ongoing contact simply involved regular monitoring and general welfare support.

4.68 A psychologist had provided support to an assistant psychologist who had been delivering some therapies to a small number of patients. They also provided training to two health care assistants so that some low intensity therapy groups could be offered. This input had now ended, which meant there was no psychology service. There was no pathway for individuals with neurodevelopmental needs, such as those with attention deficit hyperactivity disorder, and significant gaps remained for those with anxiety and mood disorders, who struggled with prison life.

4.69 Seven patients were reasonably well supported under the care programme approach (mental health services for individuals diagnosed with a mental illness) with most individuals presenting as stable. Very few patients had required a transfer to hospital under the Mental Health Act, and waiting times for transfers were short.

Substance misuse treatment

4.70 The substance misuse services team made a consistent contribution to drug strategy meetings, but there was no clear action plan in place. However, partnerships were good, and the team received referrals from the prison, based on testing and intelligence.

4.71 Ninety patients were on opiate substitution therapy (OST) supported by three clinical staff, one of whom was very new in post. Treatment was individually tailored and reflected clinical guidelines. The caseload was large, but there was clear evidence from the records and patient reviews we observed of good collaborative working. The clinical team, including the clinical lead staff member (who was a prescriber and also temporarily providing clinical leadership to the mental health service), was routinely deployed to administer drugs, which created risks.

courses with external support for rugby, enabling participants to join sports clubs in their home areas on release. (See paragraph 1.43.)

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 areas of concern, 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.

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

Overall effectiveness: Requires improvement

Quality of education: Requires improvement

Behaviour and attitudes: Good

Personal development: Requires improvement

Leadership and management: Requires improvement

5.16 Leaders had improved the quality of education, skills and work at the prison since the previous inspection and had achieved most of the recommendations. Senior leaders and managers made sure that education, skills and work were priorities within the prison. They worked collaboratively with the education provider to improve the standard and breadth of activities available to prisoners and held each other to account effectively for factors affecting prisoners' experiences during activities. They made sure that there were sufficient education and part-time work opportunities for the population, and very few men were unemployed. Pay rates did not discourage prisoners from attending education.

5.17 Education and prison managers accurately identified areas for improvement in education, skills and work activities. Education managers provided teachers with effective coaching and useful

professional development, which prison instructors also attended. However, prison managers did not make sure action was taken swiftly enough for improvements to be made promptly in workshops.

5.18 Leaders considered the curriculum carefully. They made sure that the education, skills and work offered were sufficiently broad to meet the varying needs of prisoners. They considered the specific needs of younger prisoners appropriately and were due to broaden activities for this group, such as through the Duke of Edinburgh Award. However, leaders struggled to recruit staff to fill vacancies at the prison. This meant too many prisoners could not access qualifications or activities that would help them progress into employment when they were released. For example, catering, cleaning, and painting and decorating qualifications had not been available for a long time.

5.19 Leaders did not make sure that the English and mathematics learning needs of the population were met. Too many prisoners could not access functional skills classes or outreach support quickly enough. The small proportion of prisoners for whom English was not their first language received support from outreach staff and mentors. However, no English for speakers of other languages (ESOL) qualifications were available and they did not make progress in line with their English-speaking peers.

5.20 Staff provided prisoners with good careers guidance during induction. Information, advice and guidance staff conducted purposeful discussions with prisoners about their prior knowledge, skills and wider interests. They used this information to create meaningful personal learning plans that were shared with staff responsible for allocations. Prisoners received up-to-date and relevant information about the opportunities available to them in education, skills and work. As a result, prisoners could make informed choices about their activities based on their current skills levels, interests and aspirations.

5.21 Prisoners were allocated to activities taking account of their career aspirations, but they waited too long to start activities to meet these needs. Waiting lists were too long. Most prisoners were allocated to work to match their interests or existing skills in the meantime, but too few gained new skills or knowledge in these activities.

5.22 Prisoners did not gain a realistic experience of work in preparation for their release, as most of the work places were only part time. Too few prisoners who were eligible for release on temporary licence (ROTL) were able to access employment in the community. Only four prisoners had been able to access work through ROTL at a nearby café since COVID-19 restrictions had been lifted in April 2022. Managers did not check that prisoners in full-time wing work were purposefully occupied at all times during employed hours. Prisoners could not achieve basic qualifications in roles, such as food hygiene and health and safety, to support their ability to work safely on the wings.

5.23 Leaders made sure that prisoners could develop their skills in real commercial environments. For example, those working in the

engineering workshops fulfilled Ministry of Defence contracts while gaining qualifications in engineering operations. They skilfully engineered component parts and constructed equipment for use across the Prison Service, and serviced and repaired equipment for the Ministry of Defence.

Welding workshop

5.24 Teachers in education and skills were well qualified and experienced. Most prison instructors were also highly experienced in their vocational areas. However, too few instructors had teaching or training qualifications. Managers had introductory training courses planned for instructors but they had not yet been held.

5.25 Teachers and instructors planned and sequenced learning logically, sensibly and carefully to meet prisoners' needs. Most established prisoners' existing skills and knowledge effectively and used the information to inform their teaching. For example, staff assessed prisoners' backgrounds and motivations on the peer mentoring course. They made sure prisoners understood the rules related to the role before moving on to analyse the strengths and weaknesses of different leadership styles. In construction, prisoners learned basic health and safety in the workshop first. They then learned essential practical skills, such as mixing mortar and creating the correct bonds in bricklaying, before moving on to more complex aspects.

5.26 Most teachers and instructors presented new information to prisoners clearly. They explained new concepts, describing their relevance in a wider context. This meant prisoners acquired new skills quickly when they were in learning environments. For example, in horticulture prisoners received helpful advice and practical guidance so they could complete a range of tasks from an early stage in the course, such as

digging out and building a pond. However, too few prisoners in vocational training completed in-cell work packs and in too many subjects prisoners did not gain a secure grasp of underpinning theories.

5.27 Teachers and instructors carefully checked prisoners' understanding in learning environments. They helped prisoners to relate new topics to previous concepts taught, or to their existing skills. Prisoners applied their learning to solve practical and theoretical problems and to improve their writing skills. For example, in cooking the individual coaching prisoners received helped them to correct errors in technique. Most teachers gave prisoners useful feedback to help them produce work to a high professional standard. However, most instructors did not identify in enough detail what prisoners needed to do to improve the quality of their work and prisoners were unsure about how they could do better.

5.28 Teachers and instructors understood prisoners' support needs. They adapted their teaching methods and resources appropriately. Outreach teachers provided high-quality one-to-one support so that prisoners could improve their English and mathematics skills swiftly. Teachers used information from initial learning needs assessments to identify and apply sensible strategies to help those with learning difficulties or disabilities to make progress in line with their peers.

5.29 Most prisoners who enrolled on qualifications achieved them, but in prison-led activities too few prisoners accessed qualifications that would have improved their employment prospects. For example, in waste management, Waste Management Industry Training and Advisory Board and employability qualifications were available, but too few prisoners chose to complete them.

5.30 Instructors did not set targets, monitor or record the progress prisoners made in workshops or work areas effectively. While progress tracking booklets were in place in all areas, too many instructors did not use them effectively to help prisoners with their personal development, or with their employment-related or practical skills. This meant prisoners were unsure about how they could improve their employment prospects or how transferable their skills were.

5.31 Attendance at education, skills and work had improved significantly in recent months and was now good. However, too many prisoners did not attend their activities on time because movements were staggered.

5.32 Prisoners treated each other and staff with respect. They behaved well in learning and work activities. Prisoners' relationships with each other improved through their interactions during education and the working environment. For example, the football academy enabled prisoners to develop good relationships and respect for prisoners they previously refused to communicate with.

5.33 Teachers and instructors helped prisoners to develop positive attitudes to learning and future employment. Prisoners had clear employment goals as a result of good-quality careers advice and guidance. Most

were determined to succeed, took part in work tasks and were proud of their achievements. They understood that maintaining employment while in custody would support them to gain and sustain employment once released.

5.34 Prisoners in vocational training and workshops had a good understanding of safety. For example, in construction prisoners used the correct personal protective equipment and adhered to safety requirements at all times. Prisoners in horticulture used tools safely in the garden areas. Those in home cooking gained a good knowledge of safe working practices, such as risks related to cross-contamination, working with high-risk foods, and the importance of cleanliness in their work area.

5.35 Prisoners were proud of their contributions to the prison and wider community. Those in essential areas, such as the kitchen, appreciated their role in the running of the prison. Cleaners made sure that the prison was a pleasant environment in which to learn, work and live. Those in waste management recognised the difference their work made to the environment, while in the cycle workshop, men appreciated the chance to use their existing skills to contribute to the community.

5.36 Staff organised events and activities to raise prisoners' awareness of a range of aspects related to living in modern Britain. However, only a small proportion of prisoners took part in these events.

5.37 Prisoners did not have sufficient access to the virtual campus (prisoner access to community education, training and employment opportunities via the internet) to help them with job searches or applications. Leaders were waiting for upgrades to cabling before installing the virtual campus throughout the prison. Too few prisoners benefited from this support in securing employment as they neared release. Managers did not monitor prisoners' employment on release effectively.

Section 6 Rehabilitation and release planning

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

Children and families and contact with the outside world

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

6.1 The prison's remote location made visiting difficult. In our survey, only 16% said they had received a visit within the previous month, and only 15% said it was easy for their family and friends to get to the prison, compared to 29% in other similar prisons. Online booking, suspended during COVID-19 restrictions, had recently been reintroduced and the phone line was now only used to change visits. Several families had called the prison but had not been able to get through.

6.2 Social visits took place on Wednesday, Saturday and Sunday afternoons. Only about 100 visits a month had taken place until three months before the inspection when the number had doubled.

6.3 The prison had a 'families and significant others' strategy, which was clear, but very general. Family work was delivered in partnership with children's charity Barnardo's. The prison had recently reintroduced its popular family days, which were not limited to those on the enhanced level. A range of structured activities included some in the open air.

6.4 The visitors' centre was welcoming but had very limited catering facilities, which were soon to be replaced by a new centre with a café. The spacious and bright visits hall had been decorated and was suitably furnished with soft chairs. It had a good children's play area, overseen by a Barnardo's playworker. The menu in the café was very limited.

6.5 The prison's video calling system was under used. Despite the remote location and relatively low number of in-person visits, only 4% of respondents in our survey said they were using the service compared to 16% elsewhere. Video calls took place in a prefabricated building that was not welcoming. Prisoners complained about a lack of privacy and technical issues. The prison had identified the limited take-up and had tried to promote the service but had not done enough to respond to negative perceptions, such as the belief that the service cost money.

6.6 In-cell phones had been installed since our last inspection. Prisoners valued them and they were the main means of contacting families.

6.7 Staff from Barnardo's and a dedicated member of the substance misuse team were supporting prisoners to maintain contact with their families, including liaising with local authorities and other stakeholders.

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.

6.8 Most prisoners (95%) were serving sentences of over one year, and nearly half of those (45%) were serving long sentences of four years or more. According to the prison's needs analysis, 63% of the population had less than one year left to serve.

6.9 The strategic management of reducing reoffering was a real strength. There was a comprehensive strategy setting out the prison's vision and priorities, underpinned by good use of data, which continued to be updated frequently in line with changes in the population. Action planning was responsive and managed through reasonably well-attended monthly meetings and good efforts were made to improve outcomes for prisoners across all resettlement pathways.

6.10 Staff recruitment and retention in the offender management unit (OMU) was an ongoing challenge but was currently adequate. There were 2.8 qualified probation officer prison offender managers (POMs) and eight prison-employed POMs, three of whom were operational and sometimes redeployed to undertake other prison duties. Most POMs had an average caseload of about 50, which was mostly manageable, but some POMs did not have their training needs met and not all were operating at full capacity. As a result of losing one profiled probation officer, some prison-employed POMs were managing high-risk cases independently rather than in a supportive capacity, which did not comply with guidance under the offender management in custody model (see Glossary of terms).

6.11 A duty POM saw prisoners within about two days of their arrival and offered useful information about the OMU. Those we interviewed said they were promptly given information about key dates in their sentence and were able to check and challenge anything they felt was incorrect, which they found helpful and reassuring.

6.12 Too many prisoners arrived at the prison without an initial offender assessment system report (43% in the previous six months), which put the busy OMU under pressure to stay abreast of the backlog. Despite this, about 85% of prisoners had had some form of review in the previous 12 months. However, the reviews and sentence plans we looked at in detail varied. Some were very good, thorough and

informed, but others were brief and only focused on the offence in isolation, instead of taking account of past offending, custodial behaviour and other risk factors. There were some examples of good information-sharing, triggering a further review based on a prisoner's change of circumstances, but this did not always happen consistently, for example when a prisoner had been recalled to custody or following a re-categorisation review.

6.13 The frequency of contact between prisoners and their POMs had improved, but some prisoners remained frustrated by the lack of response to requests for information about their sentence or release planning arrangements. This was exacerbated by the lack of supporting offender management key work (see paragraph 4.4). In our survey, only 51% of prisoners who had a custody plan, said that someone was helping them to achieve their targets. Most prisoners we spoke to said contact was mostly incidental and unplanned, which meant they did not know when or if they would be seen.

6.14 The contact sessions varied. There were a few excellent examples of meaningful work being delivered that included motivational sessions focused on sentence progression. In these examples, negative or concerning behaviour was discussed and challenged using creative case management techniques.

6.15 One case within our sample demonstrated good POM efforts to mitigate the numerous obstacles the prisoner faced in working towards his targets. A progressive move to another establishment to undertake a programme had been refused and the POM thought it was too soon for him to engage with psychological services. The POM completed one-to-one victim awareness work and referred him for a distance learning violence reduction course, to help raise his offending behaviour awareness, while reducing the likelihood of his disengagement.

6.16 We also saw good examples of prompt contact between POMs and social care personal advisors to arrange three-way meetings and information exchange for some young adults who had experienced local authority care.

6.17 However, for too many others, contact consisted merely of basic check-ins, and we were not confident that sessions helped prisoners to progress. Some, especially those serving longer sentences, said they were unable to demonstrate meaningful progress because they were not given enough to do, which they found discouraging. Other prisoners said they had progressed by improving their employment skills, but not by meeting sentence plan targets or addressing their offending behaviour.

6.18 In most of the cases we reviewed, sentence progression was not sufficiently good, which was further hampered by prisoners' lack of access to a wider range of lower-level interventions and accredited programmes (see paragraph 6.30).

Public protection

6.19 A monthly interdepartmental risk management meeting provided timely oversight for prisoners subject to multi-agency public protection arrangements (MAPPA) who were approaching release, and attendance at these meetings was improving. Other prisoners' cases could be referred for discussion, based on factors such as their vulnerability or complexity. However, there was a lack of systematic oversight for some who were assessed as high risk but who were not eligible for MAPPA, which meant their risks may not have been managed.

6.20 Communication between the prison and community offender managers (COMs) to confirm prisoners' MAPPA levels and share risk and release planning information was not always timely, despite the prison's persistent efforts to escalate the matter when responses were late. Risk management plans were variable but adequate.

6.21 The prison's written contributions to community MAPPA meetings varied. Most were reasonably well-considered, but some were more descriptive than analytical. In our case sample, we considered two to be best practice examples where a good level of information had been provided, and prisoners' previous, current and future risks in custody and the community had been used to inform the assessment.

6.22 Public protection monitoring arrangements were managed reasonably well. New arrivals were screened so potential risks could be identified and recorded. During the inspection, 13 prisoners were subject to some form of monitoring. Five were considered high risk and had all their communications screened. The rest were low risk and subject to regular 'dip test' monitoring. Reviews took place and monitoring logs were up to date although some entries, particularly those relating to mail, were not always detailed enough. There were some gaps in oversight for those with child contact restrictions.

Categorisation and transfers

6.23 Re-categorisation processes were managed well. Reviews considered a good range of information and were now timely, and decisions were justified. Prisoners could contribute to the process in writing and, where a reduction in risk level was likely, they could attend their review in person. Prisoners who had been declined a lower categorisation were informed about what they needed to achieve for a better outcome, which instilled hope.

6.24 During the inspection, there were 12 category D prisoners, eight of whom were waiting to be moved to the open estate. One prisoner had been waiting since March 2022, which was too long. Staff in the OMU told us transfers to open prisons usually happened within one to two months but took longer for moves to other category C prisons for those being released locally to be closer to family or to undertake programmes. Staff described a range of factors contributing to delays, for example, a reduction in treatment programme availability across the

prison estate and prisons further afield failing to prioritise transfers from outside their area and issues with transport. One person within the OMU was now responsible for dealing with transfers but the unit did not know how many prisoners were still waiting to be moved to another category C prison.

6.25 In the previous year, 122 prisoners had been released on home detention curfew (HDC). The prison managed this process well and most prisoners were released within several days of their eligibility date. However, some waited too long for several reasons, for example, because of a lack of space at an approved premises or Bail Accommodation and Support Service (BASS) address. During the inspection, one prisoner had been waiting 118 days to go to an approved premises.

Interventions

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

6.26 Not enough was being done to determine the treatment needs of the population so as to plan provision and sequence prisoners' sentence progression appropriately.

6.27 The small programmes team continued to face difficulties in recruiting and retaining facilitators. The prison had worked creatively to upskill an officer support grade position to help with programme delivery while recruitment was under way.

6.28 The prison offered just one accredited programme – the Thinking Skills Programme (designed to help prisoners develop cognitive skills to manage their risks). During 2021, its delivery had been curtailed but it was now taking place with larger groups of prisoners. Since April 2022, 18 prisoners had completed the programme and a further 42 places were available for the rest of the year. The prison held many high-risk prisoners who were more likely to require a high intensity offending behaviour programme only available at other prisons. We were told that since May 2022, four prisoners had been transferred to undertake such programmes, but the true extent of prisoners' unmet needs had not been established.

6.29 In our case sample, we saw some evidence of communication with COMs, to make sure licence conditions included a requirement to complete programmes in the community to help meet prisoners' outstanding needs.

6.30 Some low-level one-to-one interventions were taking place, but only on a small scale. Prisoners were positive about the workbooks provided by the substance misuse service, which they found 'real life valuable', and appreciated the constructive and practical feedback they received. The prison planned to train key workers in September 2022 to deliver the Choices and Changes intervention (for young adults with low

psychosocial maturity) which was positive, especially given the proportion of young adults at the prison.

6.31 There were few release on temporary licence (ROTL) opportunities given the number who were potentially eligible. In the previous six months, two prisoners had undertaken work at HMP Verne's public café, accounting for 75 individual events. ROTL was currently not being used, but four prisoners had recently been assessed as suitable.

6.32 Resettlement staff provided finance and debt support for those assessed as presenting a low or medium risk of harm, including making referrals to open bank accounts and obtain identification. The Department for Work and Pensions (DWP) helped prisoners with their entitlements and benefit claims and in the previous 12 months, nearly 600 prisoners had received assistance. Good information sharing between the OMU and DWP made sure that prisoners being released on HDC could also get the support they needed.

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.

6.33 Over 40 prisoners were released from Portland each month. Changes in resettlement provision meant prisoners and staff were unsure about what support could be offered, by whom and when. Some prisoners we spoke to said they felt ill-prepared for their release and in our survey, only 53% of those expecting to be released in the following three months said someone was helping them to prepare for this.

6.34 The COM managed the release of high-risk prisoners. In our case sample, it was not always clear what action, if any, had been taken. Where details were available, planning was not always timely and information was not always shared with prisoners, POMs or resettlement staff.

6.35 The prison's resettlement team now consisted of just two workers and an administrator. It was responsible for seeing all low- and medium-risk prisoners 12 weeks before their release to assess their needs. We saw some examples of good quality resettlement plans with action being followed up, for example, on finance, benefit and debt advice. However, not all plans or referrals for community support services were in place soon enough to make sure prisoners' needs could be addressed adequately.

6.36 The COM had to request accommodation support for prisoners of all risk levels. In our survey, 53% of respondents said they needed help with accommodation on release. Prison data showed that about 85% of prisoners had an address to go to on their first night of release.

6.37 Interventions Alliance (a criminal justice organisation) offered accommodation support two days a week, but only when the COM instructed them to do so, and primarily only for prisoners being released in Dorset.

6.38 Prison and resettlement team staff worked hard to address some of these shortfalls, and the recent reintroduction of the multi-agency pre-release board was positive.

Section 7 Summary of priority and key concerns

The following is a list of the priority and key concerns in this report.

Priority concerns

1. **The level of assaults on other prisoners was too high.** Although lower than in 2019, it was increasing, and leaders did not sufficiently understand what was driving violence.

2. **Rates of self-harm were too high and increasing. They were among the highest compared with similar prisons**. The reasons had not been investigated sufficiently, nor was there a data-informed action plan to reduce self-harm.

3. **Not enough was being done to meet the needs of younger prisoners.** The young adults strategy was not based on a thorough needs analysis and there was no clear plan of action.

4. **Mental health services were seriously understaffed and overstretched.** Support was largely confined to providing acute and urgent care and there were no specialist psychological interventions.

5. **Leaders did not make sure that there was sufficient resource [to support the English and mathematics needs of prisoners**. Too few spaces were available or outreach support for those with the lowest levels. There was no ESOL provision.

6. **Leaders and staff did not prepare prisoners effectively for employment on release**. Almost all work was part-time, prisoners could not access essential safety qualifications and too few could access ROTL.

Key concerns

7. **Key work was not sufficient and still operating only on a priority basis.**

8. **Prisoners found the cost of basic items from the shop too high. Low incomes, rising shop prices and poor food left many prisoners frustrated.** Many told us this made issues around debt worse.

9. **The needs of foreign national prisoners were not identified or met.** The strategy for foreign national prisoners was mainly limited to immigration detainees.

10. **Provision for neurodivergent prisoners was limited.**

11. **Many prisoners spent too little time unlocked – about five hours a day – which was inadequate for a training prison.**

12. **Leaders did not ensure that prisoners could access activities or education promptly enough.** Too many qualifications and courses were not running owing to staff vacancies. Waiting lists for vocational training were too long.

13. **Instructors did not use progress trackers effectively to support prisoners in gaining transferable employment-related skills or personal development**. Prisoners were not aware of the progress they had made in these areas.

14. **Sentence planning and offending behaviour work did not sufficiently support prisoners to make progress through their sentence.**

15. **Resettlement planning arrangements were inconsistent and too many prisoners did not receive sufficient support for their upcoming release.**

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.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection, in 2019, prisoners' experience of reception and the first night centre was reasonably good but many waited too long to receive an induction. Behaviour management was weak; supervision was poor and prisoners were not motivated to behave well. Violence remained at a high level and plans designed to challenge perpetrators and support victims were poorly implemented. Governance of use of force required further improvement. Use of segregation was low but the regime remained poor. There had been an impressive reduction in the use of drugs. Self-harm had increased and was at a high level. Care for more complex prisoners had improved but care for most prisoners at risk of self-harm was inconsistent. Outcomes for prisoners were poor against this healthy prison test.

Key recommendations

Key safety processes, including violence reduction, segregation and adjudication, should be scrutinised regularly and effectively and this should be underpinned by the interrogation of routinely collected, reliable and comprehensive data which inform effective actions, the success of which can be judged by less violence.
Partially achieved

Behaviour management schemes should be implemented consistently across the prison and should focus on incentivising and motivating prisoners.
Achieved

Use of force documentation should be completed promptly and thoroughly, all planned incidents should be recorded and reviewed, data should be analysed and incidents reviewed to monitor trends, identify good practice and learn lessons.
Achieved

The ACCT process and its quality assurance should ensure that prisoners in crisis are safe and supported by adequate staff support, quality care maps and a regime that engages them.
Not achieved

Recommendations

Managers should ensure that systems for changing poor behaviour and assisting vulnerable prisoners are implemented effectively.
Not achieved

All security processes should be reviewed to ensure they are appropriate for Portland's role as a category C training prison.
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2019, despite some reasonable interactions, too many staff had low expectations of prisoners and did not consistently challenge poor behaviour. Communal areas and Beaufort wing had improved since the previous inspection but elsewhere living conditions required improvement. Cells remained cramped and poorly equipped, with inadequately screened toilets. Access to showers was poor. The quality of food required improvement. Consultation was weak as was the complaints system. Equality and diversity work had been restarted three months before the inspection and, except for the chaplaincy provision, was limited. Reasonable health services were undermined by some poor facilities and the inability to get prisoners to appointments. Substance misuse services were good. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

Staff should provide proactive support and supervision of prisoners at all times and enforce the rules consistently.
Achieved

All living accommodation should be clean, decent and fit for purpose.
Achieved

Regular consultation and monitoring should inform provision for protected groups and ensure that outcomes are fair.
Achieved

All complaints, including those made against staff, should be taken seriously and investigated promptly and thoroughly.
Achieved

Patients should have prompt access to health services, including sufficient officers to ensure safe and timely medication administration and prompt attendance at health clinics.
Achieved

from the inspection. 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 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:

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Sara Pennington	Team leader
Sumayyah Hassam	Inspector
Martin Kettle	Inspector
Jade Richards	Inspector
Paul Rowlands	Inspector
Chris Rush	Inspector
Dionne Walker	Inspector
Helen Downham	Researcher
Rachel Duncan	Researcher
Joe Simmonds	Researcher
Jed Waghorn	Researcher
Sarah Goodwin	Lead health and social care inspector
Steve Eley	Health and social care inspector
Sue Melvin	Pharmacist
Gary Turney	Care Quality Commission inspector
Rebecca Perry	Ofsted lead inspector
Corinne Baker	Ofsted inspector
Andy Fitt	Ofsted inspector
Sambit Sen	Ofsted inspector

Appendix II Glossary of terms

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

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.

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.

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).

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

Appendix III Further resources

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

Prison population profile

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

Prisoner survey methodology and results

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

Prison staff survey

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

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

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