Report on an unannounced inspection of

HMP Isle of Wight

by HM Chief Inspector of Prisons

20 September – 7 October 2022

Contents

Introduction

The Isle of Wight prison has existed in its current form since 2009, when historic Parkhurst was amalgamated with the adjacent Albany, an institution dating from the late 1960s. A third jail, Camphill, originally part of the cluster, subsequently closed and has now been decommissioned.

Designated a category B training prison and part of the long-term high security estate, the two sites contain a varied mix of accommodation types, which adds a certain complexity to the institution. That said, the prison's primary purpose is quite clear. It holds nearly 1,000 men who, with the exception of a small number of local islander remand or sentenced prisoners, have been convicted of serious sexual offences. The vast majority are assessed as presenting a high risk of harm to the public, although most are now category C, presenting a lower security risk than the majority category B population we encountered when we last inspected in 2019.

Since that last inspection, our assessments indicate that the prison had experienced a significant deterioration in some important outcomes. It was still not safe enough; outcomes in respect had worsened, and in our healthy prison tests of purposeful activity and rehabilitation and release planning, we now judged outcomes to be poor, a considerable indictment for a training prison. While we found a jail that was generally calm and settled, data about violence was mixed, there had been seven self-inflicted deaths since we last inspected and the level of self-harm, despite some useful interventions, was very high. Our observations of relationships between staff and prisoners were mixed. Some staff were attentive, but others displayed a concerning indifference which needed to be challenged.

Underpinning many of our criticisms was the lack of care and investment in the general environment of the prison. The institution had lost its way in its core mission of reducing reoffending. Prisoners had very little time out of cell, routines were unpredictable and access to work, education, and activity was intermittent. Support for rehabilitation was under resourced, and there was a lack of direction and rigour to ensure that what little did take place was effective. Offending behaviour interventions and resettlement initiatives were similarly lacking. All of this combined to create a sense of indolence and frustration among many in the prison.

Acute staff shortages, both of prison officers and more specialist disciplines, was undermining much of the prison's work and attempts at improvement. Leaders were not unaware or indifferent to this; they were proactive and creative in recruitment and the leadership support they were providing to those staff deployed to the wings. Their general assessment of the strengths of the institution and the priorities to be addressed was mostly accurate, particularly in terms of operational management, but the lack of priority or effective vision for the rehabilitative function of the prison was a considerable missed opportunity. In their use of data, for example, leaders focused on how the prison compared to other category B training prisons, and while this was understandable, it gave insufficient weight to how the establishment compared with similar lower

category prisons or those with a specialist sex offender treatment function. There was a sense that protecting the prison's status as a category B long-term establishment had become an informal priority and it was no surprise to us that it lacked the purpose and rehabilitative ethos often found in other prisons tasked with managing the risks and eventual resettlement of men convicted of sexual offences.

Leaders seemed open and responsive to our assessment during the inspection. There was clearly an urgent need to support the prison in providing the specialist resources it required, and for careful thought about the purpose of this prison. In our report we highlight a number of priorities and concerns which we hope will assist this process.

Charlie Taylor
HM Chief Inspector of Prisons
November 2022

What needs to improve at HMP Isle of Wight

During this inspection we identified 15 key concerns, of which six should be treated as priorities. Priority concerns are those that are most important to improving outcomes for prisoners. They require immediate attention by leaders (see Glossary) and managers.

Leaders should make sure that all concerns identified here are addressed and that progress is tracked through a plan which sets out how and when the concerns will be resolved. The plan should be provided to HMI Prisons.

Priority concerns

1. **The therapeutic and rehabilitative purpose of the prison was not sufficiently prioritised.** Leaders had not developed the environment or regime in a way that sought to ensure needs and risks of the sex offender population were addressed. This was compounded by a failure to respond to the new reality of a much larger population of category C prisoners. Specialist staff shortages further worsened this situation.

2. **Over a third of officers were not available for work in the units, which limited the delivery of the day-to-day regime and led to prisoners spending too long locked in cells.**

3. **The level of recorded self-harm was very high and there had been seven self-inflicted deaths since our last inspection.**

4. **Prisoners had very limited access to work or study.** Planned access was severely undermined by poor attendance, poor punctuality and prisoners returning to their cells early.

5. **There were significant gaps in release planning for prisoners many of whom posed a high risk of serious harm to the public.**

6. **The health provider had identified risks to service delivery and patient outcomes, but improvements had not taken place quickly enough.**

Key concerns

7. **Data were not used well enough to improve outcomes.** Managers did not explore outcomes at other prisons holding a similar population, including those convicted of sexual offences and category C prisoners. They did not evaluate the impact of the education and skills curriculum to drive improvement.

8. **Many of the residential units were shabby, bleak and in need of significant repair.**

9. **Black and minority ethnic and Muslim prisoners and those with mental health problems were far more negative than their counterparts about some key aspects of their care, for example, their relationships with staff and the safety outcomes they experienced.**

10. **Mental health and learning disability services did not provide adequate or timely evidence-based care or treatment.**

11. **There was insufficient oversight of, and control over, medicines creating risks to staff and patients.**

12. **Leaders had not prioritised reading or literacy.**

13. **Leaders did not make sure that prisoners could access education promptly enough to make progress towards their career aspirations.**

14. **Prison offender managers did not have enough contact with prisoners or access to interventions to help them address their offending behaviour.**

15. **There was too little support to help prisoners maintain or rebuild ties with their families and friends and no reliable resettlement help for those being released.**

About HMP Isle of Wight

Task of the prison/establishment
A designated category B male training prison predominantly for prisoners convicted of sexual offences with a small local remand function.

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 971
Baseline certified normal capacity: 1,064
In-use certified normal capacity: 916
Operational capacity: 1,009

Population of the prison
- 564 new prisoners received in the previous 12 months.
- 113 foreign national prisoners.
- 22% of prisoners from black and minority ethnic backgrounds.
- 53 prisoners released into the community in the previous year.
- 201 prisoners receiving support for substance misuse.

Prison status and key providers
Public

Physical and mental health provider: Practice Plus Group
Substance misuse treatment provider: Practice Plus Group, subcontracted to the Midlands Partnership Foundation Trust and Inclusion
Prison education framework provider: Milton Keynes College
Escort contractor: Serco

Prison department
Long-term high security estate

Brief history
HMP Isle of Wight opened in April 2009 following the merger of three prisons – Albany, Parkhurst and Camp Hill. Albany was constructed in the 1960s and occupies the site of a former military barracks. Parkhurst was originally a military hospital and became a prison in 1863. Camp Hill was built in 1912 using prisoner labour from Parkhurst but closed in April 2013.

Short description of residential units
Albany – house blocks 11–17.

Parkhurst – houseblocks 19–25. House block 18 was closed for refurbishment.

Name of governor and date in post
Dougie Graham, May 2018

Changes of governor/director since the last inspection
Steve Phillips, acting governor, Feb 2022
Theresa Orford, acting governor, Oct 2021

Prison group director
Will Styles

Independent Monitoring Board chair
Hazel Hall

Date of last inspection
15 April – 2 May 2019

Section 1 Summary of key findings

1.1 We last inspected HMP Isle of Wight in 2019 and made 35 recommendations, 15 of which were about areas of key concern. The prison fully accepted 25 of the recommendations and partially (or subject to resources) accepted three. It rejected seven of the recommendations.

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

Progress on key concerns and recommendations from the full inspection

1.3 Our last inspection of HMP Isle of Wight took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for prisoners at the time. Although we recognise that the challenges of keeping prisoners safe during COVID-19 will have changed the focus for many prison leaders (see Glossary), we believe that it is important to follow up on recommendations about areas of key concern to help leaders to continue to drive improvement.

1.4 At our last full inspection, we made 15 recommendations about key concerns. At this inspection we found that five of those recommendations had been achieved, nine had not been achieved and one was no longer relevant.

1.5 Both recommendations made in the area of safety had not been achieved. Of the six recommendations in the area of respect, three had been achieved and three had not been achieved. Two of the recommendations in the area of purposeful activity had been achieved and two had not been achieved. Two of the recommendations in the area of rehabilitation and release planning had not been achieved and one was no longer relevant. Three of the recommendations not accepted were in the area of respect and one was in the area of rehabilitation and release planning.

1.6 For a full summary of the recommendations achieved, partially achieved and not achieved, please see Section 8.

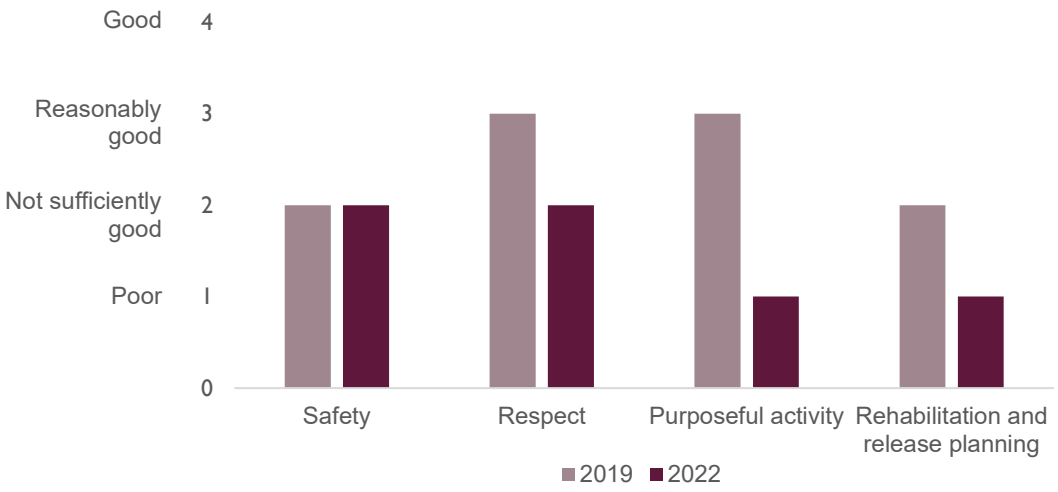
Outcomes for prisoners

1.7 We assess outcomes for prisoners against four healthy prison tests (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.8 At this inspection of HMP Isle of Wight, we found that outcomes for prisoners had stayed the same in one healthy prison area and declined in three.

1.9 These judgements seek to make an objective assessment of the outcomes experienced by those detained and have taken into account the prison's recovery from COVID-19 as well as the 'regime stage' at which the prison was operating, as outlined in the HM Prison and Probation (HMPPS) National Framework for prison regimes and services.

Figure 1: HMP Isle of Wight healthy prison outcomes 2019 and 2022



Safety

At the last inspection of Isle of Wight in 2019 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

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

1.10 New prisoners received welcoming, well delivered support in reception in addition to welfare checks during the first night. The use of peer workers to support new prisoners through their early days was good. The induction programme had been restructured but only started once a week, which meant some prisoners had to wait to join it. The induction for the few remanded prisoners from the island was poor.

1.11 Prisoners' perceptions of safety remained similar to 2019 with a quarter feeling unsafe at the time of this inspection. However, in our survey, Muslim prisoners, those from black and minority ethnic groups and prisoners with mental health problems had significantly more negative perceptions of their safety. Recorded rates of violence had decreased by about 20% since the previous inspection and levels were now lower than many category B and C prisons. However, the overall recorded rate of violence was the highest of all other establishments holding prisoners convicted of sexual offences. The rate of assaults against staff had increased since the last inspection while the rate of prisoner-on-prisoner assaults had declined. Most violent incidents were not serious. Not all incidents were investigated promptly or in sufficient

detail, and behaviour management processes such as challenge, support and intervention plans (see Glossary) were not fully effective.

1.12 Despite an increase in the level of assaults on staff, the number of times force had been used remained similar to the previous inspection. Too few staff used body-worn cameras during use of force incidents, which was not acceptable. The use of segregation had declined significantly, and reintegration planning was now more effective. The segregation unit environment was clean and well maintained and staff-prisoner relationships were good.

1.13 There had been some positive improvements to physical security since our last inspection, including the introduction of a body scanner on each site and the installation of more CCTV, but some measures were disproportionate, including excessive searching in reception without an assessment of the risks posed by the individual.

1.14 There had been seven self-inflicted deaths and a considerable increase in the rate of self-harm since our last inspection. Leaders had prioritised supporting the small number of prisoners who contributed to a large proportion of the self-harm incidents. However, assessment, care in custody and teamwork documentation for prisoners at risk of suicide and self-harm was inadequate.

1.15 Partnership working with the local adult safeguarding board was good, but we were concerned that officers had little understanding of the risk of abuse that vulnerable prisoners potentially faced.

Respect

At the last inspection of Isle of Wight in 2019 we found that outcomes for prisoners were reasonably good against this healthy prison test.

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

1.16 In our survey, prisoners' perceptions of their relationships with staff were reasonably good overall, but the experience of some prisoners with protected characteristics was significantly worse. Just under half of the prisoners responding to our survey said they had felt victimised by staff, describing staff antagonising them or making discriminatory comments. We saw many polite interactions alongside some examples of care and compassion. However, staff shortages meant officers often did not have enough time to build meaningful relationships and key work (see Glossary) delivery was poor. Some officers did not supervise the units well enough, and we saw staff failing to manage or challenge poor behaviour effectively.

1.17 Most prisoners lived in single cells. Despite some refurbishment, many units were shabby, bleak, and need of significant repair. The condition of many showers was poor, but the few that had been refurbished were considerably better. The night sanitation system (see Glossary) on the

Albany site was working reasonably well, but the communal toilets were in poor condition. Prisoners could have a portable toilet in their cell when queues for the sanitation system were long, but staff had also allowed the use of plastic buckets, which was disrespectful, and they did not have access to a sink so they could wash their hands.

1.18 Work to promote equality was reasonable, but the action plan was not updated often enough. The prison was analysing and responding to a range of quantitative data and forums took place for prisoners in most protected groups. Disabled and older prisoners received a good range of support and transgender prisoners were generally well cared for, but the support for foreign national prisoners was too limited. Our survey showed black and minority ethnic and Muslim prisoners, as well as those with mental health problems, had far more negative experiences in some key areas, compared with their counterparts.

1.19 Although leaders had identified concerns and had credible plans to improve health care, progress was too slow. There was not enough GP capacity to meet demands. Staff shortages meant the integrated mental health team was unable to offer a full range of interventions, and psychiatry input was insufficient. End-of-life and palliative care arrangements were very good and social care had improved significantly. Patients received good psychosocial and clinical support to help address addiction problems. Oversight and governance of medication were insufficient, the storage and management of controlled drugs was ineffective and not all medicines could be accounted for. Dental care was in line with expected standards.

Purposeful activity

At the last inspection of Isle of Wight in 2019 we found that outcomes for prisoners were reasonably good against this healthy prison test.

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

1.20 Time out of cell (see Glossary) was considerably worse than at the last inspection and the regime was not always delivered reliably. We saw delayed unlocking times and the weekend regime was particularly poor with frequent curtailments and regime shutdowns. Activity sessions were often cancelled or undertaken with reduced numbers because of the lack of staff. During our roll checks, 32% of the population were locked in their cells during the working day, which was double the proportion we found in 2019.

1.21 The two libraries were closed due to a lack of prison staff and the book delivery and collection service was not a sufficient alternative. Both gyms were good, but the outdoor sports provision was limited.

1.22 Ofsted judged that education, skills and work was inadequate. Leaders and managers had not made sure the curriculum was ambitious. They had not implemented an effective reading strategy and the education

strategy focused on meeting minimum functional skills targets. Not all teaching staff had suitable qualifications.

1.23 Leaders and managers did not have adequate oversight of the quality of education skills and work and did not make good use of data to evaluate effectiveness. Long waiting lists and restricted numbers allocated to activities had an impact on the ability of prisoners to get on appropriate English for speakers of other languages, English and mathematics courses.

1.24 Too few prisoners made progress or achieved their qualifications, and most spent as little as six hours a week in education with poor attendance and punctuality causing further limitations. Activities were, too often, cancelled, or numbers were restricted due to the absence of instructors. In addition, prisoners sometimes could not go to their activities because of the lack of officers.

1.25 Teachers planned lessons effectively and prisoners received good support from peer workers. The pay policy offered prisoners appropriate incentives to study subjects such as mathematics and English, including bonuses for completing and passing courses. Information, advice and guidance (IAG) support was effective in assisting prisoners with their short- and medium-term goals, but not their long-term goals.

Rehabilitation and release planning

At the last inspection of Isle of Wight in 2019 we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

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

1.26 The support prisoners received to help them rebuild ties with family and friends was too limited. Many were far away from home, making visits difficult, and one third of the population had never had a visitor. In-cell telephones were a valuable mitigation and video calling was very popular, but sessions were sometimes cancelled, and there were none available in the evening or at weekends.

1.27 The prison held a complex group of prisoners convicted of sexual offences. Most were serving long sentences and 80% were assessed as posing a high risk of serious harm to others. Two thirds of the population were, however, now category C prisoners, compared to 11% when we last inspected. Some prisoners arrived having already been downgraded to C and many also had relatively little time left to serve in prison, adding to the complexity of offender management challenges. There was also a small remand population serving the needs of the Isle of Wight itself.

1.28 There was no comprehensive or up-to-date analysis to make sure that the provision met the needs of the new population, but it was positive that more than 500 offender assessment system reports had been

reviewed in the previous year and most of the ones we looked at were good.

1.29 There was an acute shortage of probation officers, which meant caseloads were very high and unmanageable. As a result, contact was poor and, in our survey, far fewer than at our last inspection said they understood what they needed to do to achieve their sentence plan objectives.

1.30 There were not enough progression opportunities and many prisoners, especially the category C population, were very frustrated and described a feeling of hopelessness. Despite prison staff's efforts, very few prisoners were able to move to other prisons to progress or receive resettlement help.

1.31 Public protection work was very weak. Prisoners presenting a high risk of harm who were due for release were not routinely identified or discussed at a multidisciplinary forum to make sure risk management plans were robust. We found examples of a lack of a confirmed multi-agency public protection agency management level and, in some cases, a lack of suitable accommodation for release. Phone monitoring was not well staffed and, although initial child contact restrictions were applied swiftly, there was a large backlog of applications for contact waiting to be dealt with.

1.32 Progress in delivering accredited programmes at pre-pandemic levels had been slow because of staffing problems and only 30 prisoners had completed one in the previous two years. About 50 prisoners were meant to complete an accredited programme in the current year and places were appropriately prioritised. Half the population was assessed as being in some level of denial and very few had completed an intervention to motivate them to complete a programme.

1.33 The number of releases was increasing, and there had been 53 in the previous 12 months, but the prison was not resourced to provide resettlement help. About one in five prisoners had been released without accommodation.

Notable positive practice

1.34 We define notable positive practice as innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

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

1.36 Prisoners leaving the segregation unit received good support to reintegrate onto the main wings. For example, reintegration plans now included activities, such as attending the gym or undertaking domestic

tasks with those from the house block that the prisoner was due to return to. (See paragraph 3.27.)

Section 2 Leadership

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

2.1 Good leadership helps to drive improvement and should result in better outcomes for prisoners. This narrative is based on our assessment of the quality of leadership with evidence drawn from sources including the self-assessment report, discussions with stakeholders, and observations made during the inspection. It does not result in a score.

2.2 Leaders' assessment of the prison's overall strengths and challenges had led to an appropriate set of priorities. However, there were few measures of success against which to monitor progress and the key weaknesses in education, skills and work and the risks posed by poor offender management had not been identified or properly prioritised.

2.3 The use of data to improve outcomes and monitor effectiveness was too limited in some areas, including education, skills and work. Leaders had not clearly determined the underlying reasons for the very high levels of self-harm and suicide, although their focus on supporting those who self-harmed frequently was sensible.

2.4 Leaders monitored the prison's performance through comparisons with category B training prisons, but given the prison largely held a category C population, this did not provide a full picture. A wider analysis, using category C prisons or other comparable prisons also holding a full population of prisoners convicted of sexual offences, would have added to this evidence base. This approach was consistent with a theme amongst leaders that gave great weight to the prisons status as a category B training prison in the High Security Estate rather than the new reality, that being the prisons role as a specialist prison for sex offenders, most of whom were of now lower category.

2.5 The number of staff leaving had increased this year and HM Prison and Probation Service (HMPPS) projected that the situation would get worse over coming months. Just over a third of main grade officer posts were either vacant or not deployable to operational duties and there were significant gaps in the operational support staff group. Despite proactive recruitment activities and overtime payments, there were shortages on a day-to-day basis, which led to ongoing restrictions to the regime and regular curtailments.

2.6 Acute shortages in specialist staff, including prison offender managers, psychologists and mental health workers, undermined the possibility or potential that the prison could work toward a therapeutic and rehabilitative ethos that should be key to a prison like HMP Isle of Wight. Leaders had not developed the day-to-day regime or environment to support the new population of category C prisoners, who described their frustrations about some of the restrictions and rules, which they felt were similar to those in a higher security prison.

2.7 Due to staff shortages, leaders had not been able to make sure that attendance and punctuality at education was sufficient. Attendance in most industries and work settings was satisfactory, but too much learning time was lost through poor punctuality and delays in starting work.

2.8 Despite an increase in the number of prisoners being released directly from the prison, leaders had not strengthened their risk management release planning arrangements and did not have enough staff to provide basic resettlement help.

2.9 The membership of the senior leadership team had changed considerably over the previous year, and many senior leaders were new to their posts. Despite this, they worked well together and in our staff survey, 26% said that leaders always set high standards of behaviour for staff and 40% said this often happened.

2.10 Very recent improvements to managerial oversight and accountability had been made by increasing the number of custodial managers. Our survey showed that this was a useful improvement as staff currently had very mixed views about leaders' and managers' willingness to challenge poor behaviour and their level of approachability.

2.11 Improving communication was a priority and a new strategy had been developed to support this. Newsletters were issued regularly to staff and prisoners and the governor led monthly meetings with prisoner representatives and had restarted full staff meetings. In our staff survey, 24% said the priorities were very clearly communicated and 48% said they were communicated quite clearly. Most staff said they agreed with the priorities.

2.12 The governor took the task of improving staff culture and well-being seriously and had begun to address concerns raised in an independent report. This included establishing a multidisciplinary team to deliver improvements, alongside a committee, more staff support systems and staff well-being events. Despite these efforts, our survey results and discussions with staff during the inspection showed very mixed views about their morale and well-being.

2.13 One in five officers had less than two years' experience and had only worked during the COVID-19 restrictions. A training needs analysis had been completed to make sure that required training was provided but this did not include broader skills training such as trauma-informed approaches, working with challenging behaviour or mental health awareness and some staff we spoke to said this was a gap.

2.14 HMPPS leaders had not made sufficient investment in the living conditions at either site. Many units were now shabby, worn and beyond basic repair. Despite this, leaders at the prison made sure the prison was kept clean and provided prisoners with good access to basic cleaning materials.

Section 3 Safety

Prisoners, particularly the most vulnerable, are held safely.

Early days in custody

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

3.1 In the previous year, there had been 539 new prisoner arrivals. Coming from across England and Wales, this meant most had had very long journeys, including one or two overnight stops at other prisons before arriving at the Isle of Wight. It followed that many prisoners were being held significant distances from their home areas.

3.2 The reception area was clean, and the main holding room was well furnished and had a good range of information for newly arrived prisoners. Other smaller, less well-equipped holding rooms, we were told, were rarely used.

3.3 In our survey, 89% of prisoners said they were treated well in reception, which was confirmed by our observations. Staff were welcoming and took time to explain processes. Procedures were efficient, and most prisoners spent less than two hours in reception. The vast majority of those responding to our survey (82%) said searching was undertaken respectfully, a search which included both a body scanner and also strip-search. The decision to complete both searches was not based on an individual risk assessment.

3.4 Initial interviews were held in private in reception and were appropriately focused on promoting safety. This focus extended to the early days unit, with a peer-led introductory talk and welfare checks by staff during the first night in the prison.

3.5 First night cells were of a reasonable standard, but the condition of some communal areas, including bathrooms, needed improvement.

3.6 In our survey, almost all prisoners (91%) said they had been through the induction programme, but as it only started on Mondays some waited far too long to access it. During this time they had very little time out of their cell due to the limited day-to-day regime.

3.7 The programme delivered to most prisoners had been restructured and now lasted five days. It was peer led but also included information from a good range of departments, such as offender management, education, and substance misuse services. Despite this, significantly fewer prisoners than at our last inspection (55% compared with 70%) said it covered everything they needed to know.

Induction room

3.8 Induction arrangements for prisoners from the island who were on remand or serving short sentences were poor. They did not have access to the full induction programme that other prisoners experienced and the amount of information they received was far too limited to enable them to be fully aware of the range of support available in the prison.

Managing behaviour

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

Encouraging positive behaviour

3.9 Results from our survey showed that prisoners' perceptions of safety remained similar to our last inspection, with half reporting that they had felt unsafe at some point during their time at the prison and a quarter saying they felt unsafe at the time of this inspection. Prisoners from ethnic minority groups, Muslim men and those who had mental health problems had significantly more negative perceptions of their safety. For example, 46% of prisoners from black and minority ethnic groups, compared with 18% of white prisoners, reported that they felt unsafe at the time of the survey, and 62% (compared with 24% of white prisoners) reported that they had felt unsafe at some point during their time at the prison. (See also paragraphs 4.1 and 4.32.)

3.10 While recorded rates of violence had decreased by about 20% since the previous inspection, they were the highest of all other

establishments holding prisoners convicted of sexual offences. There had been 132 violent incidents in the previous 12 months, which included 70 assaults on staff and 62 prisoner-on-prisoner assaults. The rate of assaults on staff had increased since our last inspection while the rate of assaults between prisoners had decreased. Most incidents were not serious but, in the last year 16 had led to prisoners or staff attending hospital for treatment.

3.11 Prisoners' behaviour was not managed robustly. Our survey found that only 37% felt that the incentives scheme encouraged them to behave well and just 33% said they had been treated fairly, compared with 55% and 51% respectively in 2019. Those we spoke to said that being on the enhanced level gave them few rewards, and some also told us that they saw enhanced prisoners behaving badly on the wings without being challenged by staff, which did little to improve their own feelings of safety. We found evidence of this, and some prisoners remained on the enhanced level despite continuing to behave very poorly, for example, victimising, bullying and stealing from other prisoners. Oversight of prisoners on the basic level of the incentives scheme was insufficient and one prisoner had been on this level for almost two months without a review.

3.12 Challenge, support and intervention plans (see Glossary) were not used effectively to manage perpetrators or victims of violence and not all incidents of violence were investigated quickly enough or in sufficient detail. In one incident, a prisoner reported that he had been threatened in his cell and that other prisoners had stolen his property. The investigation into the incident was delayed and those accused were not questioned about the allegation, despite information reports suggesting they had previously victimised other prisoners in a similar way. Instead, they remained on the enhanced level of the incentives scheme.

3.13 Oversight of prisoners who were self-isolating required improvement, especially for those in distress or at risk of self-harm. Staff awareness of those who had chosen to self-isolate was too limited, which meant these prisoners did not always participate in the daily regime or have meaningful contact with staff.

3.14 Leaders had introduced a safety strategy which focused on appropriate priorities, such as the reduction of violence. However, understanding of the levels of violence was hampered because leaders only compared the establishment to other category B training prisons, where the levels tended to be higher and more serious. A comparison with category C prisons (more representative of the current population) and those holding prisoners convicted of sexual offences would have provided a more detailed and considered comparison.

3.15 Available data was not always analysed thoroughly or used well enough to drive improvements. For example, safety meetings focused on monthly changes in the number of staff assaults rather than increasing trends over time, and there were no realistic measures of success to make sure leaders were achieving positive outcomes.

Adjudications

3.16 There had been 1,021 adjudications in the previous 12 months, most of which concerned assaults or prisoners' refusal to follow orders from staff. Serious incidents were appropriately referred to the police for investigation.

3.17 In the sample of records we reviewed, prisoners were often given insufficient detail about why they had been placed on report, and adjudications were not always used a last resort.

3.18 Some charges were dropped because they were not served within the correct timescale, and as a result poor behaviour went unchallenged. At the time of our inspection, too many hearings (about 80) remained adjourned because of delays in accessing camera footage, some of which dated back three months.

3.19 Regular quality assurance by the deputy governor had identified some procedural issues but the wider issue of ineffective management of behaviour was not being addressed.

Use of force

3.20 Despite an increase in the number of assaults on staff, the rate of use of force remained similar to the previous inspection. There had been 242 incidents in the previous 12 months, about 90% of which were spontaneous. Data recorded by the prison found that most use of force happened when staff intervened to prevent harm to other prisoners or staff, or because prisoners refused orders.

3.21 In the previous 12 months, there had been six incidents where a baton had been drawn but not used. Each of these had been investigated appropriately by managers. In the camera footage available for review, there was evidence of staff using de-escalation techniques well to prevent situations escalating further.

3.22 Oversight of most of the remaining use of force incidents was insufficient. The monthly committee meetings were poorly attended and continued to be held remotely using video technology. Although a useful range of data was discussed, there was no scrutiny of camera footage. The safer custody team reviewed a couple of incidents each month, but this was too few to provide assurance that interventions were generally necessary or proportionate.

3.23 Too few staff used their body-worn video cameras to de-escalate incidents or provide evidence of prisoner behaviour, there being no footage available for about 40% of incidents. In addition, it was difficult to understand why staff chose not to use the handheld camera to record every planned incident.

3.24 Oversight of the use of special accommodation was reasonable and took place at the quarterly segregation, monitoring and review group (SMARG) meeting, at which decisions and records were appropriately scrutinised. Special accommodation had been used seven times in the

previous year and, in most instances, prisoners were removed from these conditions as soon as possible – mostly within 10 minutes – once there was evidence that they were calmer and communicating with staff in a more positive way.

Segregation

3.25 There had been 171 instances of segregation in the previous year, which was a significant reduction since our last inspection. The environment in the unit remained reasonably good being both clean and well maintained. The regime was restricted to one hour a day in the exercise yard, a 30-minute telephone call and time for a shower. Prisoners told us that the daily routine was delivered reliably despite its manifest limitations and austerity. Outside exercise yards remained cage-like and austere.

Segregation exercise yard

3.26 Staff-prisoner relationships were, despite this, good. Prisoners we spoke to said they felt respected by staff who had a good knowledge of their problems. Our survey found that of those who had spent one or more nights in the segregation unit, 82% said staff treated them well. A quarterly SMARG meeting provided reasonable oversight of segregation decisions assisted by a use of data that was improving.

3.27 Most prisoners returned to the main wings after typical stays of about 13 days in the unit (see paragraph 1.36). The prison had focused on enhancing reintegration planning, making it practical and specific to the individual needs of the prisoner. For example, plans now included activities, such as attending the gym or carrying out domestic tasks with those from the house block that the prisoner was due to return to. Prisoners could also progress to the upper landing of the unit and gain

more privileges such as a TV in their cell. They told us this encouraged them to behave better.

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.

3.28 There had been some positive improvements to physical security since our last inspection, including the introduction of a body scanner on each site and installation of more CCTV.

3.29 Leaders used additional security measures, such as closed visits, proportionately. However, some other measures were not proportionate or based on an individual risk assessment: for example, it was not necessary to strip-search prisoners being released into the community. In addition, all prisoners being escorted to outside hospital appointments had to wear a prison-issue uniform, without an individualised assessment of their risk of escape. This even applied to men who had been assessed as suitable for living in an open prison and were waiting to move on.

3.30 The security department received about 800 information reports each month, which enabled analysts to identify relevant threats. The manager was appropriately focusing on improving the quality of information submitted. Information sharing was good and there was a daily meeting that enabled staff to act on any new information received. This was supported by a monthly security meeting.

3.31 Leaders had good working relationships with the police and other agencies to help manage prisoners from serious and organised crime groups or those who posed a threat of extremism.

3.32 In our survey, far fewer prisoners (29%) said it was easy to get illicit drugs in the prison, compared to the last inspection (42%). A reasonable drug strategy was in place, supported by quarterly meetings. Leaders had been carrying out random mandatory drug testing but not consistently and there were insufficient data to measure the level of drug use across the sites. There was a lack of intelligence-led drug testing to identify and challenge prisoners who were misusing substances, with only four tests carried out in the previous 12 months.

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

3.33 There had been seven self-inflicted deaths since our last inspection, including one that tragically occurred during this inspection. Prisons and Probation Ombudsman (PPO) investigations had highlighted common failings, such as inadequate welfare checks on prisoners and poor management of in-possession medication. While leaders were implementing recommendations, they did not routinely make sure action was embedded. The PPO was still investigating two self-inflicted deaths. It was positive that leaders had changed some practices to reflect lessons learnt immediately after these incidents.

3.34 The rate of self-harm had increased significantly since our last inspection and, in the year before this inspection, there had been 1,275 incidents, which was the third highest of all adult male prisons in England and Wales. Over half of the self-harm had, however, been attributed to a small number of individuals. To their credit leaders had achieved some reduction in self-harm throughout 2022 by taking a good multidisciplinary approach to supporting and managing these most vulnerable prisoners.

3.35 Leaders had put in place a new safety strategy that included sensible objectives, including improving care planning and targeting support for first time self-harmers. However, there was too little focus on addressing the underlying causes of self-harm, for example bullying, tackling prisoners' sense of hopelessness due to their lack of progression and breakdown in family contact (see paragraph 6.18).

3.36 The safety team collected a useful amount of data and information, but they did not feature in the monthly safety meeting so trends could be monitored, and areas of concern targeted to support the reduction of self-harm.

3.37 In our survey, 27% of prisoners said they had been on an assessment, care in custody and teamwork (ACCT) document for prisoners at risk of suicide or self-harm, but only 48% of them said they felt cared for. Those we spoke to during our inspection also described a lack of care.

3.38 The standard of ACCT documentation was inadequate. For example, risks and triggers were not fully identified, and care plans were limited, and did not set clear action to support the prisoners appropriately. Most daily entries from staff did not demonstrate that they had had meaningful interactions with the prisoner. Quality assurance was not

carried out consistently, and information gained was not used to drive improvements.

3.39 Constant supervision, used for prisoners who were in extreme crisis, had been used 47 times in the previous year, mostly for relatively short periods. We were concerned about the oversight of prisoners, as cases we looked at showed that reviews were not chaired by a manager who was higher than a senior officer. Prison leaders had raised this in their strategy for improvement.

3.40 There was a large team of Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) across both sites. They told us the prison and the local Samaritans coordinator supported them well, meeting them regularly at each site. In our survey, only 44% of prisoners said it was easy to speak to a Listener, but leaders had not fully explored the barriers to using the scheme.

3.41 The safer custody hotline was available for families to use if they were concerned about a relative at the prison. We tested it and received a very swift response.

Protection of adults at risk (see Glossary)

3.42 An appropriate adult safeguarding policy was in place, which was reassuring given the large number of vulnerable prisoners. Partnership working with the local adult safeguarding board was good, but most prisoners were not from the local area, and prison leaders had to make referrals to other regions of the country for concerns about vulnerability on release. (See also paragraph 4.50.) However, we were concerned that officers in the units had little understanding of the adult safeguarding risks that vulnerable prisoners potentially faced.

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 In our survey, 74% of prisoners said staff treated them with respect and 71% said they could turn to somebody for help. However, our survey showed that experiences for prisoners with some protected characteristics was significantly worse. For example, just 33% of Muslims said staff treated them with respect, compared with 80% of those who were not Muslim; for black and minority ethnic prisoners, the figure was 58% compared to 80% of white prisoners. Of those with mental health problems, 61% felt they were treated with respect compared to 90% of those without. (See paragraph 4.32).

4.2 We saw generally polite interactions between staff and prisoners, as well as some good examples of care and compassion, particularly in some of the specialist functions, such as in reception and segregation (see paragraphs 3.3 and 3.26). While many prisoners could identify individual members of staff who were helpful, many also said some were antagonistic or made discriminatory remarks. In our survey, 47% of prisoners said they had been victimised by staff. Staff shortages inevitably reduced the amount of time staff had to build meaningful relationships, which was exacerbated by the lack of effective key work (see Glossary).

4.3 While in the majority of cases prisoners could tell us who their key worker was, only 31% said a member of staff had checked on them in previous week to see how they were getting on. Most of the recorded key work was generic and did not address sentence progression and, in our survey, only 60% of prisoners said their key work sessions were helpful. The recent introduction of a new staffing profile provided officers with designated time to carry out key work, which leaders (see Glossary) hoped would improve the standard.

4.4 Staff supervision in some of the units was limited and particularly challenging at the Albany site, where the layout of the residential units inhibited observation and supervision. Officers also congregated in offices rather than proactively overseeing prisoners and we came across some staff failing to challenge low-level poor behaviour, such as vaping, or to diffuse tense situations when locking up.

4.5 There was strong use of peer workers to support and help other prisoners in some areas such as health care and on the residential

units, but the role was not yet established in safer custody. This left a gap in providing support to those at risk of self-harm or violence.

Daily life

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

Living conditions

4.6 Living conditions were not good enough at either site. Some refurbishment was being undertaken but there had been a long-term lack of investment by HMPPS. Conditions in many parts of the prison were tired, bleak, and in need of significant repair. Many cells were shabby. Although most were reasonably well-equipped, many did not have curtains.

Cell without curtains

4.7 Some communal areas were damp and mouldy with peeling paint and damaged flooring, despite prisoners making every effort to keep them clean. The communal toilet areas were in a very poor condition and needed replacing.

Communal toilet area

4.8 In our survey prisoners were reasonably positive about their access to showers, with three-quarters saying they could have one every day. A few showers had been refurbished and were of a good standard, but most were in a poor condition and not all on the Parkhurst site afforded sufficient privacy.

4.9 Most prisoners on the Albany site did not have a toilet or sink in their cell but used an electronically managed night sanitation system, which allowed them to be released from their cell for a few minutes to use the communal toilets. Although the system worked reliably overall, prisoners could have a portable toilet in their cell to mitigate any problems. However, staff also allowed the use of plastic buckets, which was disrespectful. Prisoners had no access to handwashing facilities after using them.

4.10 Access to prison clothing and bedding remained good. The onsite laundry was out of use, but sensible arrangements had been made to have the laundry done at another prison. In our survey, 78% of prisoners said they got clean sheets each week and 83% said they got enough clean clothes.

4.11 Many of the outdoor areas were neglected, particularly at the back of the house units. Exercise yards were either bare or contained very limited equipment.

4.12 In our survey only half of the prisoners said that their cell call bell was answered within five minutes, which was concerning given the high rate of self-harm. Some prisoners on the Albany site said that officers did not always respond in person to calls made through their intercom system. Management oversight of response times was limited because

the electronic monitoring system was out of use and manual checking by managers had only recently started.

Residential services

4.13 In our survey, 46% of prisoners said the food was very or quite good and only 39% said they got enough to eat. The menu was reviewed regularly, and prisoners had the option of having two hot meals on some days. Breakfast packs were delivered at lunch time the day before and other meals were often served too early.

4.14 Food was delivered to both sites from the main kitchen outside the prison grounds. Equipment was generally in good working order. Oversight of the meal service was limited. For example, catering staff had not recently visited serveries, temperature checks were completed in some units but not in others, and servery workers did not complete any food safety courses.

4.15 There was a lack of consultation about the food. While a survey had been undertaken and had led to some small changes, consultation meetings had only just resumed.

4.16 The lack of self-catering equipment was a deficiency, given the long-term population that the prison held. Most units only had a toaster that prisoners could use, and a couple had fridges.

4.17 Only 38% of prisoners said the shop catered for them which was lower than at our last inspection (62%). The shop list was often discussed at various forums and leaders were aware of prisoners' frustrations about the provision but not enough had been done to address this.

4.18 Those we spoke to were particularly concerned by the rising prices of products and many told us there was a growing number of unavailable items. Prisoners could not buy any chilled products, which was a further source of frustration.

4.19 A large number of catalogue items were ordered, but prisoners we spoke to were not aware of the comprehensive range of catalogues available to them. There had been a move to online shopping, which meant not all retailers produced physical catalogues and prisoners were often unaware of what was available. They often relied on family and friends or a member of staff to order items for them.

Prisoner consultation, applications and redress

4.20 Consultation was good overall. Forums in units brought together staff and prisoners and were effective in addressing some basic issues. In addition, consultations bringing together managers and representatives from all units on each site took place every month, but feedback on progress made in taking forward issues raised was too limited. Prisoner representatives also had the chance to meet the governor or his deputy monthly. A wide range of concerns was raised at this forum, but as it had only recently been introduced, it was not clear whether, and to what extent, issues would be addressed.

4.21 During the COVID-19 restricted regime, the governor had introduced a process in which prisoners could complete a form outlining their ideas and feedback, addressed directly to him and senior managers. This had proved useful and was being continued.

4.22 A few months before the inspection, leaders had identified that the application system was not working effectively and had improved it. Requests that could not be dealt with in the units were now processed centrally, scanned and uploaded onto a database and then sent to the relevant department for consideration. The prison now tracked and monitored progress, identifying and addressing any issues, such as delays in prisoners receiving a response.

4.23 Over the previous 12 months, there had been a steady increase in the number of complaints with a total of 3636 made. The prison had not done enough to find out the reasons for the increase.

4.24 Over 80% of responses to complaints were on time and the business hub manager quality assured about 10%. Those we reviewed had generally been well investigated and received appropriate responses, but some alleging violence were not dealt with appropriately.

4.25 Complaint themes and trends were monitored and analysed well but, in our survey, only 32% of prisoners said they thought complaints were usually dealt with fairly. Leaders had undertaken a survey of prisoners about the complaints process and were already aware of this lack of confidence but had yet to formulate a robust response.

4.26 Legal provision was mixed. Remand and other prisoners could book legal visits, which took place in appropriate private areas. The libraries had a good stock of legal texts, but the lack of physical access undermined their usefulness.

Equality, diversity and faith

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

Strategic management

4.27 Oversight of equality work was reasonable. An equality adviser was supported by two custodial managers, although the latter also undertook other duties for at least half of their time. There were also officers with specific equality roles, but because of staffing constraints they were rarely available.

4.28 A good strategy linked to an action plan was in place. However, the action plan was not reviewed or updated regularly. Data analysis was generally good, and the prison was identifying disproportionate outcomes for prisoners. Equality meetings chaired by the governor or his deputy, which had been taking place every two months, had recently been rescheduled to take place every month. Although the meetings involved senior staff from key areas, the attendance of others was lower than we usually see. There were prisoner equality representatives in most units who provided prisoners with information. The equality adviser convened meetings of the representatives, which provided them with oversight.

4.29 There had been 175 discrimination incident reporting forms (DIRFs) submitted over the previous year, which was similar to the period leading up to our last inspection. However, over half of those submitted (88) were not accepted as a DIRF because they were considered not to raise discrimination issues. They were usually referred to the complaints process or followed up in another way. However, we found many of the decisions to exclude submissions from the DIRF process were not justifiable.

4.30 Where DIRFs were accepted, the prison had identified that there were delays in replies and issues with the standard of responses. Measures had been taken, including training staff. Responses were checked by the equality adviser before they were sent and 10% were quality assured by a senior manager, with a further 10% being scrutinised by the Independent Monitoring Board. Those we reviewed were generally timely and well investigated, and responses were appropriate and well written.

4.31 Consultations took place with prisoners from most protected characteristic groups, largely through forums. They had been taking place every month, but because of a lack of equality staff time, had recently been rescheduled to take place quarterly. Managers gathered useful information to help them gain an understanding of prisoners' concerns, but it was not always included in action plans.

Protected characteristics

4.32 Over a quarter of prisoners were from a black and minority ethnic background and forums for these prisoners took place on both sites. Our survey showed prisoners from this background had far more negative perceptions in many areas than their white counterparts, as did Muslim prisoners compared with non-Muslim prisoners (see also paragraph and 4.1). The prison was already aware of many of these concerns, but little had been done to explore or address them.

4.33 There were 117 foreign national prisoners, but the provision to meet their needs was limited. Forums only involved those with a good level of English and issues raised were not always followed up. Frontline staff lacked an awareness of the existence of telephone interpreting services and the prison did not monitor their use. A very limited amount of information for prisoners was translated into languages other than

English. Although none of the prisoners were held under immigration powers during our inspection, we spoke to several who had immigration-related concerns. Although immigration officials had visited in the early part of the year, there was no indication when they would return.

4.34 In our survey, 44% of prisoners said they had a disability. Many of those with a physical disability received a good range of support, with some cells adapted to meet their needs. Most prisoners with limited mobility were placed in ground floor cells. House block 17 provided particularly good support and had trained 'buddies', who assisted prisoners with tasks, such as collecting their meals and keeping their cells clean. Disability liaison officers had been trained as trusted assessors and could identify and respond to some needs.

4.35 Provision for those with hidden disabilities was more limited, but there had been efforts to make sure that written communications were in plain English and used graphics. Managers had identified that a disproportionate number of prisoners with hidden disabilities were on the basic level of the incentives scheme, which was being explored at the time of the inspection.

4.36 The prison's 12 transgender and non-binary prisoners were supported well on an individual basis. Forums for prisoners from LGBT communities took place on both sites.

4.37 In our survey, 38% of prisoners were aged 50 or over and 5% were 70 or older. Retired prisoners were not locked up during the working day. The gym provided dedicated sessions for pensioners during which they could exercise or play board games. Good partnership work with voluntary organisations promoted dementia awareness among relevant staff and peer workers. Prison figures showed 14% of prisoners were under the age of 30. Provision for this group was limited, although a forum had been introduced.

Faith and religion

4.38 In our survey, only 44% of prisoners said they could speak to a chaplain of their faith in private compared with 66% last time. The small chaplaincy was supplemented by sessional chaplains. There were vacancies for two chaplains, which left the team very stretched across the two sites.

4.39 Both sites had good spaces for services and faith-related activities, but the roof in the chapel at the Albany site had been leaking for some considerable time. Corporate worship had resumed after COVID-19 restrictions had been relaxed, but staffing issues meant Christian services were taking place during the week, which clashed with prisoners' other activities. In our survey, only 65% of prisoners said they could attend religious services, in contrast to 91% during our last inspection.

4.40 Joint working between the chaplaincy and other departments to meet prisoners' rehabilitative objectives was more limited than we usually see. This was at least partially, but not solely, due to staffing constraints.

Health, well-being and social care

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

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

Strategy, clinical governance and partnerships

4.42 Governance structures were in place, including regular and well attended quality assurance and local operational meetings with strategic partners. The provider understood the risks to service delivery and patient outcomes, but action to reduce risks and embed service improvements was implemented too slowly. Immediate improvements were required to address delays in the mental health transfer process, tackle poor record keeping and provide a more effective response to medicines management incidents. Responses referred to in clinical reviews following deaths in custody were also deficient and required action. Senior leaders had noted the slow progress on quality improvements and plans were in place to set up a patient safety incident review forum (PSRG) to address this deficit.

4.43 There was a strong culture of reporting incidents and evidence of regular clinical audits, but, despite some poor audit outcomes, few action plans had been progressed. Plans were in place to address this within the new PSIRF.

4.44 Staffing levels had improved in the primary care service, but mental health, GP and pharmacy teams were struggling with capacity, which created delays in service delivery.

4.45 Staff we spoke to felt managers supported them and they were offered regular training and group supervision. However, not all mental health staff had adequate time for reflective practice. Training figures shared with inspectors showed deficits, but imminent training dates had been scheduled.

4.46 Prisoners told us that staff were caring and treated them with decency and respect, but they found accessing services could be challenging and the lack of response to applications created further uncertainty about how they could receive care. Our survey results indicated that it

was much more difficult to see a GP or nurse since our last full inspection.

4.47 Every patient had a single record and notes were of a good standard, but we noticed that some case notes were missing, while others lacked a rationale for prescribing decisions or had been written days after the patient had been seen. These concerns had not been addressed promptly, which was not acceptable.

4.48 Clinical areas were clean, and the inpatient department was particularly spacious, but safe accessible rooms for use by the mental health team were limited.

4.49 Well-equipped emergency bags were held in the health unit on each site. Competent paramedics and nurses responded to medical emergencies.

4.50 A new safeguarding pathway was in place that included joint working between the health care team, the prison and the local authority, which was seeing improvements in reporting safeguarding concerns. (See also paragraph 3.42.)

4.51 There were some delays in confidential health complaints being logged because health staff did not collect forms from the units consistently. Replies were comprehensive, apologetic when required and addressed the problems raised.

Promoting health and well-being

4.52 A comprehensive health and well-being improvement strategy had been developed in partnership with the prison. Health and prison staff continued to deliver the strategy throughout the pandemic, which was commendable.

4.53 Health promotion material was visible across the prison and was available in alternative languages for those whose first language was not English. Notice boards had several posters focusing on current health campaigns, and health champions in each unit promoted health and well-being among prisoners.

4.54 NHS age-related health checks and screening programmes were delivered, and any delays were managed well. A registered nurse took the lead on sexual health with a pathway in place for external in-reach services to provide more complex care where required. Patients had access to COVID-19 vaccinations and health staff actively promoted uptake.

4.55 Barrier protection was available on request, and health staff had created discrete cards so they could request it in confidence.

Primary care and inpatient services

4.56 All new arrivals received a comprehensive health screening to identify any medical needs. Their urgent needs were addressed on the same

day, and the GP triaged all new arrivals remotely. Prisoners' medical records were requested promptly with their consent, and all new arrivals were encouraged to join the GP-to-GP scheme, where notes could be shared between GPs within the prison and outside the prison to improve information sharing and continuity of care.

4.57 A wide range of primary care services was available between 7.30am and 5.30pm on Monday to Friday, with reduced levels of nursing staff at weekends. Although the provider was commissioned to deliver a round-the-clock service, staffing levels were often too low to provide emergency cover at night at both sites and in the inpatient unit. This meant that emergency responses on the Parkhurst site were often provided by the local ambulance service. The onsite GP provided weekday out-of-hours' cover, alongside a remote out of hours' service based on the mainland at weekends.

4.58 Patients' applications for appointments were appropriately triaged, and a clinician screened remotely those asking to see a GP to determine whether they could be seen by a nurse or advanced nurse practitioner (ANP) instead. Despite the use of a remote GP and an additional remote GP support mechanism, at the time of the inspection there was not enough onsite GP capacity to meet the demand of the population – only one GP was covering the two sites. The waiting time to see a GP was up to six weeks, which was too long, but urgent appointments were available on the same day.

4.59 Physiotherapy and podiatry referrals were made by the GP or ANP, and the administration team managed clinics well offering new appointments within two weeks, which was impressive. An optician provided fortnightly clinics alternating between the two sites, with appointments available within one month.

4.60 The number of patients with a long-term condition was very high, and the primary care team was in the process of rolling out new care planning tools for those with complex health needs. Long-term conditions clinics were held regularly to make sure annual reviews were completed on time, and patient records reflected the care plan for each patient.

4.61 Secondary care appointments were robustly managed by the administration team, which had built positive working relationships with prison staff to manage the high volume of external appointments. Twelve slots were available every day, which appeared to meet the needs of the population and allowed for additional travel time where appointments were not on the island. Strong oversight of cancellations was maintained. Good links with hospitals meant that appointments were rebooked promptly and those with urgent referrals to external services had their cases expedited without delay.

4.62 Patients received an appropriate pre-release assessment, and those needing medication on release were given seven days' supply.

4.63 The 18-bedded inpatient unit provided mental health, physical health, and social care beds. There was an admissions and discharge policy, and a memorandum of understanding was in place to inform the patient pathway and all admissions were based on clinical need. End-of-life and palliative care arrangements were very good.

4.64 Assessments were timely and comprehensive. Nurses could see patients around the clock. At night the nurses responded to emergencies on both sites.

4.65 Living conditions were good, the rooms were clean and spacious and well equipped. There was regular access to outside areas and patients had access to minimal activities.

4.66 Reintegration planning was in place and managed by the GP and inpatient unit nurses. The mental health team attended a weekly ward round.

Social care

4.67 There was a comprehensive memorandum of understanding between the prison and the local authority, which set out in detail how the social care pathway worked. Social care had improved significantly since our last full inspection. We spoke to several prisoners who were receiving a social care package (see Glossary) or who had peer support, and most were complimentary about the care they received. Those with full care packages could receive care up to four times a day.

4.68 Peer support workers were selected, trained and supervised and worked closely with disability liaison officers (see also paragraph 4.34). Equipment was supplied through agreed processes, although some prisoners complained that there had been delays in getting equipment once it had arrived at the prison.

Mental health care

4.69 The integrated mental health team worked hard to deliver a stepped care model despite staffing shortages. Team members offered some community-equivalent interventions, but there were no groups running and those waiting were not given a date for when their intervention would start. However, one-to-one work helped tackle the deficit. The focus of team members was on triage, assessment and crisis intervention, which resulted in more stable patients being seen less frequently. Not all patients had care plans.

4.70 The psychiatry provision was inadequate. The psychiatrist attended two sessions per week, which created delays in assessments, prescribing, care program approach reviews (for individuals diagnosed with a mental illness) and mental health transfers. Clinical records showed that clinical consultations were not always recorded in a timely manner, which had the potential to create a risk to patients.

4.71 The learning disability and neurodevelopmental service was limited because of a reduced learning disability nursing presence, affecting the

assessment of and treatment planning for patients with a learning disability. Clinical records we saw showed that patients had not received follow up. There was no psychologist, which meant patients had less access to trauma-informed interventions and treatment. There were no personality disorder or diagnostic pathways for autism or learning disability patients.

4.72 All referrals were triaged and appropriately screened, and all urgent cases were seen within 24 hours, but some routine referrals had not been seen within the required timeframe. All referrals who were triaged but not accepted for assessment received a letter from the triage nurse informing them of this.

4.73 There were 19 patients on the care programme approach who were receiving good support for enduring mental illness, and a small group of prisoners could access treatment for post-traumatic stress. Multidisciplinary reviews took place in a timely manner.

4.74 The team attended all initial assessment, care in custody and teamwork (ACCT) case management reviews for those at risk or suicide and self-harm and subsequent reviews for patients on their caseload.

4.75 Since October 2021, there had been 20 referrals to a secure environment. Two men continued to wait for a transfer – one had been waiting 214 days and the other 63 days. The weekly meeting with the health commissioner responsible for expediting transfers had not taken place since August.

Substance misuse treatment

4.76 The substance misuse service Inclusion worked well across the prison. Substance misuse and drug strategy team managers worked closely and were part of a well-attended drug strategy meeting. Staff from Inclusion also attended the external community strategic substance misuse partnership as part of an island-wide approach to addiction services.

4.77 Patients' substance misuse needs were being met by a well-led and adequately resourced service. The team comprised well-trained and supervised clinical nurses and recovery workers who provided a timely response to patient needs.

4.78 All new arrivals were screened for drug and alcohol issues in reception and saw clinical prescribers as necessary. Clinical prescribing was appropriate, flexible and in line with evidence-based treatment. The clinical prescriber made sure appropriate clinical reviews took place and where appropriate, they were held jointly with the recovery worker. Fifty-nine patients were receiving opiate substitution therapy at the time of the inspection.

4.79 Planning for group work had started but had been delayed and there were no mutual aid groups, which was poor.

4.80 There were six recovery peer mentors, three on each site, overseen by a lead recovery worker who was also responsible for training new mentors. Peer mentors we spoke to were enthusiastic and proud of their role in helping others.

4.81 Recovery workers attended all ACCT reviews for patients on their caseload. They also visited any patient on a newly opened ACCT to assess and discuss any possible substance misuse concerns and offer them their service, which was good.

4.82 Release arrangements for patients who lived on the Isle of Wight were reasonable, and Inclusion staff contacted community services for those released onto the mainland to make sure all prisoners had follow-up appointments. Naloxone (used to reverse an opioid overdose) was provided to prisoners on release, if appropriate.

Medicines optimisation and pharmacy services

4.83 The pharmacy delivered its services adequately, but only one of the two pharmacists was in post, which created weaknesses in oversight.

4.84 Medicines were dispensed by the in-house pharmacy as patient-named items. Most medication was stored and transported adequately. But controlled drugs (CD) were transported across both sites using a sealed bag, with no security escort. The team was looking into purchasing lockable boxes. Temperature-sensitive medicines were kept in fridges, which were monitored.

4.85 The management of CDs in the pharmacy was not sufficiently robust. There were some expired CDs among up-to-date stock, and significant quantities of obsolete and patient-returned CDs needed to be destroyed. Running balances of CDs were not audited at regular intervals and a balance check of morphine sulphate tablets did not match the recorded balance. It was reported to us that the practice of reusing named-patient returned CDs had stopped following a recent NHS England review. The CD cabinets in the clinic rooms at both Albany and Parkhurst sites were too small to hold CDs safely.

4.86 Prescribing and administration were carried out through SystmOne (the electronic clinical information system). Medicines were administered mostly by nurses three times a day and night-time medication was issued as daily in-possession medicine. In-possession risk assessments were attached on SystmOne, but reviews were generally triggered following an incident. About 51% of patients received their medicines fully in possession, 26% weekly in possession and 2.2% daily in possession. Spot checks of in-possession medication were mainly intelligence-led and undertaken when staffing levels permitted.

4.87 The prescribing of tradeable medicines was well-controlled so that only a few patients received them. A range of emergency medicines were available to allow patients access out of hours and administration was recorded on SystmOne. However, there were no reconciliation procedures for medicines used in the administration rooms.

4.88 Staff reported incidents on Datix (the electronic health care incident reporting system) but reviews relating to mitigating similar events in the future were not effective. There was no pharmacy-led clinics due to staff shortages.

4.89 Patients who did not attend medication administration sessions were not always followed up in line with local operating procedures. Drug and therapeutic meetings were held at a local and regional level, to which the pharmacy team contributed.

Dental services and oral health

4.90 Dental care was delivered at an acceptable standard by suitably qualified and supervised staff. Patients were initially seen by a dental nurse to identify urgent issues and emergencies were seen at the following dental clinic, where reserved slots were available.

4.91 Most patients were seen by a dentist or dental therapist within six weeks. An initial appointment was used to examine and assess patients' treatment needs, followed up with a treatment plan, which offered them a suitable range of NHS treatments. Medicines were prescribed using the electronic patient record and supplied on site. There were emergency drugs in the surgery and oxygen and a defibrillator nearby.

4.92 Surgeries were in working order and equipment was well maintained. The floor in Parkhurst was not compliant with infection, prevention and control guidance and needed to be renewed. There were no decontamination rooms, but working processes were safe.

Section 5 Purposeful activity

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

Time out of cell

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

5.1 The amount of time prisoners spent out of their cell had decreased since our last inspection. The published regime was meant to allow prisoners in full-time education, training or work about eight hours out of their cell from Monday to Thursday and at least five and a half hours on a Friday. Unemployed prisoners could expect only one hour 45 minutes out of their cell per day during the week.

5.2 During our roll checks, an average of 32% of prisoners were locked in their cells during the core working day, which was twice the proportion compared to our last inspection. At our last inspection, 54% of prisoners were away from their unit in work, education or training, but during this inspection the figure had decreased to 36%. We found that many of the prisoners who had been designated as being in full-time work were locked up, most often because of a lack of instructors. The proportion of prisoners working in the units was the same as during our last inspection (22%) and many of them were still not fully occupied.

5.3 The regime had been subject to frequent changes in the previous year and in our survey, 84% of prisoners said they knew when the unlocking and locking-up times were supposed to be, which was lower than the last time we inspected (94%). Only 28% said that the regime was delivered reliably, which was also lower than at our last inspection (60%). We saw examples of delayed movements to and from activities and units being locked down due to a lack of staff.

5.4 At weekends, the published regime was meant to allow prisoners up to six hours a day out of their cells, but this was not being achieved. The prison often ran a split regime, where prisoners were only unlocked in the morning or the afternoon. There were also other curtailments even when the split regime was in force. In our survey, 28% of prisoners said they usually spent less than two hours out of their cell on a typical Saturday or Sunday, which was higher than last time (10%).

5.5 There was no longer any designated association time, but it was anticipated that prisoners would participate in structured unit activities particularly at weekends. Most prisoners did not have access to them in practice because of reduced unlocking times and limited access to recreational equipment.

5.6 During the week, prisoners only had 30 minutes of outdoor exercise, usually from 8.15am in the morning. Many prisoners felt this was too early and we noted that there was limited take-up on most wings. Managers informed us that prisoners could exercise outdoors for an hour at weekends, but this amount of time was not mentioned in the published regime and prisoners told us they were outside for the same amount of time as during the week.

5.7 There was one library on each site, and both were well run. They had been shut for much of the pandemic and had reopened two months before our inspection. Since they had reopened, prisoners' access had been sporadic, mainly because of a lack of prison staff to escort and supervise them. In our survey, only 22% of prisoners said they could visit the library once a week or more, which was lower than the 54% at our last inspection. Those we spoke to were extremely frustrated by the lack of access.

5.8 During our inspection, leaders (see Glossary) had closed the libraries again due to the shortage of staff. The delivery and collection service, which had been in operation during the pandemic was being resumed. Many prisoners we spoke to indicated that they found it difficult to know what items to request without the opportunity to browse.

5.9 Gym facilities on both sites were good and since our last inspection much of the equipment had been replaced. The prison had resumed a comprehensive gym programme, which included early morning sessions for those in work or training, as well dedicated sessions for workers in the units, older prisoners and those on drug recovery programmes. The gym had also started taking referrals for remedial exercise again for those with health conditions. No PE was taking place in the evenings.

5.10 Indoor team sports, including cricket and football were available. Outdoor provision was limited. On the Albany site, only a part of the sports field was being used for football. There were no outdoor sports facilities on the Parkhurst site.

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.

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

Overall effectiveness: Inadequate.

Quality of education: Inadequate.

Behaviour and attitudes: Require improvement.

Personal development: Inadequate.

Leadership and management: Inadequate.

5.12 Leaders and managers had not made sure there were adequate spaces in education, skills and work for prisoners. At the time of the inspection some courses were not scheduled for delivery, one was not running due to staff shortages and too many prisoners waited too long to be allocated to a course in English, mathematics and English for speakers of other languages (ESOL). The curriculum was not ambitious enough for the prison community, and there were not enough opportunities in the curriculum or in work for progression.

5.13 Leaders over-allocated prisoners to workshop places to achieve contract performance targets, but this resulted in too many prisoners being returned to their cells without any purposeful engagement. Instructors tried to make sure that it was not always the same prisoners being returned to their cells, but this was only an informal process. As a result, too many prisoners did not benefit from consistent opportunities to learn or practise their vocational and employability skills or access support from peer mentors and staff.

5.14 Leaders and managers had not made sure the curriculum was ambitious or appropriate for all prisoners. Prisoners following education courses had too few opportunities to gain qualifications beyond level 2. In the work environment, leaders and managers had not provided prisoners with higher-level roles to aspire to, such as supervisory roles. In industrial settings, prisoners were demotivated and frustrated by the lack of accredited qualifications, which would have recognised the valuable skills they had learned and enabled them to record them. Leaders had not been able to work around significant staff shortages, which had led to many vocational courses being cancelled.

5.15 Leaders and managers had not been ambitious in improving prisoners' reading skills and had not implemented an effective strategy. Due to staff shortages, prisoners were unable to access the library at regular intervals (see paragraphs 5.7 and 5.8). Teachers had received little training on using phonics (which aims to improve prisoners' fluency and

accuracy in their use of words) to support prisoners in the early stages of developing and improving their reading skills.

5.16 ESOL teachers did not conduct assessments that enabled them to identify who was literate in their own language and who was not. Consequently, they did not have a good understanding of prisoners' support needs or knowledge of their starting points, so they could plan learning and peer support that enabled them to develop their English language skills.

5.17 Prisoners studying speaking and listening skills could not access books that supported their literary interests, or which enabled them to explore new areas of learning.

5.18 Senior leaders did not have an accurate oversight or understanding of the quality of education, skills and work. They recognised some strengths and weaknesses, but not how key weaknesses restricted prisoners' access to high quality education, work and skills. Prisoners were not being prepared well enough for the next steps in their prison career or for their release. Quality assurance arrangements were superficial and had not been used by managers to inform improvements or further staff training and development.

5.19 Leaders did not make effective use of data to evaluate the effectiveness of curriculum planning. Consequently, they were unable to make swift interventions to reduce excessively long waiting lists for prisoners wanting to start courses. For example, nearly half of prisoners waited over 100 days to access basic English and mathematics courses. Some prisoners waited over a year to access an ESOL course. These delays frustrated and demotivated prisoners.

5.20 The minimum English and mathematics entry requirements for access to jobs and industry were often disregarded. This prevented prisoners from developing these skills before progressing to skills and work activities.

5.21 Prisoners had limited access to study periods. Most prisoners who attended courses in the education department spent only six hours a week in education. Their poor attendance and punctuality further restricted time for study. Consequently, too many prisoners made too little progress and did not achieve their qualifications.

5.22 Prisoners frequently arrived late to their learning and work sessions. This was due to staff shortages, delaying prisoners' movements to activities. Teachers and trainers did not encourage the few prisoners who arrived on time to start work while waiting for others to join. As a result, prisoners delayed sitting down at their desks or workspaces, and instead made drinks or chatted to their peers. Teachers and trainers often ended sessions early because prisoners were being escorted back to their unit before the sessions were finished. As a result, prisoners were not developing a positive work ethic.

5.23 Prisoners completed a comprehensive induction within the first two weeks of arrival at the prison. They were each provided with an overview of the range of education, skills and industry opportunities available. As a result, prisoners gained an introduction to the options available to them, including entry requirements. Peer mentors provided well-planned inductions to industry and work, making sure prisoners understood what the training entailed and how to work safely. However, prisoners did not benefit from appropriate careers advice so not all of them understood the often limited career opportunities available to them.

5.24 All teachers had a teaching qualification or were working towards one. Teachers planned lessons well to meet the individual needs of prisoners. They used information gathered from prisoners' assessments to devise relevant learning activities. In lessons for non-English speakers, and functional English and mathematics, teachers used peer mentors effectively in class to help prisoners develop the knowledge and skills required to achieve their qualifications.

5.25 Peer mentors worked towards and achieved level 2 certificates in mentoring and level 3 certificates in providing information, advice and guidance. They also completed short courses in safeguarding and managing learning difficulties and disabilities. However, only a small number of courses were run each year, consequently too few prisoners were able to work towards the qualifications required to be a mentor.

5.26 Most prisoners demonstrated a good understanding of equality and diversity. They understood the importance of treating others with respect. Leaders and managers used 'community values' to promote equality and diversity. Teachers and instructors included relevant topics in some sessions. This was particularly effective in English at the Albany site and in the personal development classes at the Parkhurst site. However, not all teachers and instructors used opportunities to further promote and discuss these values and topics during their sessions.

5.27 Managers acknowledged that tutors' planning for prisoners' personal development was not consistently good across all aspects of education, skills and work. They recognised that the tracking and monitoring of personal skills development required improvement particularly in the workshops.

5.28 Leaders and managers had planned a curriculum to support the personal development of prisoners, in particular their resilience and confidence and keeping mentally and physically healthy. However, most of these courses had been cancelled or were only available at one site. For example, courses on well-being, mental health, personal finance and healthy living were only available at Parkhurst.

5.29 Most prisoners received helpful advice and guidance during their induction period and ongoing support that enabled them to plan for their short- and medium-term goals. However, leaders had not planned an appropriate curriculum to support category C prisoners to develop

the knowledge, skills and behaviour that prepared them well for their next steps. Prisoners with long sentences did not have access to a well-planned curriculum that supported them to plan successfully for their prison career.

5.30 The provision of careers information, advice and guidance was poor. Too few prisoners benefited from ongoing advice and guidance about their future career options. Prisoners did not have access to the virtual campus (internet access for prisoners to community education, training and employment opportunities) to conduct job searches. During induction, they were set unrealistic or vague career-related targets. Prisoners did not have a clear understanding of what they were working towards.

5.31 The prison's pay policy offered prisoners appropriate incentives to study subjects such as mathematics and English, including bonuses for completing and achieving qualifications. However, staff shortages prevented prisoners from attending these lessons. Activities were, too often, cancelled, or numbers were restricted due to the absence of instructors.

5.32 Leaders from the education provider, Milton Keynes College, had not worked closely with prison leaders to plan an education or vocational curriculum that met the needs of prisoners. Education leaders did not make sure that teachers of mathematics and some vocational subjects were appropriately qualified.

5.33 The level at which prisoners were learning English and maths did not support their vocational interests. As a result, they were unable to apply their learning effectively in their work activities. Prisoners did not make the progress of which they were capable and too many failed to achieve their qualifications in a timely manner.

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 Prisoners received very limited support to help rebuild or maintain ties with their families and friends. Many prisoners were far away from home with, for example, about 40% of the population from the Northwest, Northeast, Midlands or Wales. As a result, some families and friends had long and costly journeys to get to the prison, which included transport on and off the island and often overnight accommodation.

6.2 Hardly any prisoners received regular social visits and one third of the population (319 prisoners) had never had a visit at all. In our survey, only 4% of prisoners said they had been able to see their friends and family in person more than once in the previous month.

6.3 Social visits had been reduced to three sessions a week on Friday, Saturday and Sunday and were hardly ever fully booked. The prison's website had no up-to-date information about visiting times or how to contact the visits booking clerk. Visitors who travelled long distances could book sessions on successive days to make their visit worthwhile.

6.4 The visitors' centre, an ageing portacabin, remained inadequate. Barnardo's provided support in the centre but had only been allowed to offer advice and play in the two visits halls since June 2022, when COVID-19 restrictions had been lifted. There was new furniture in both visits halls, which was an improvement.

6.5 Video calling, new since the last inspection, was very popular. However, sessions were sometimes cancelled due to staff shortages causing regime curtailments and there were no sessions in the evenings or at weekends. In-cell phones, also new since we last visited, were a valuable addition and appreciated by prisoners.

6.6 Prisoners had to change into prison-issue clothing not just for social visits but also for video calls, which was unnecessary.

6.7 There had not been any family days since the pandemic, although one was due to be held in the Albany visits hall in late October. Only a

handful of prisoners had participated in the Storybook Dads scheme (in which prisoners record stories for their children). There was no individual family engagement casework to help prisoners reconnect with families where this was helpful for their rehabilitation. There was no official prison visitor scheme to support those who never got a visit.

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 The prison held a complex group of prisoners, almost all convicted of sexual offences. Most prisoners were serving long sentences and about 80% were assessed as presenting a high risk of serious harm to others. About two-thirds of the population now had category C status, compared to just 11% when we last inspected: some had achieved category C status at the prion while others had been transferred to the jail as category C prisoners. This change had taken place because of a national shortage of spaces for these prisoners and it meant that the population no longer matched the stated function of the establishment as a category B prison. Some of these prisoners arrived with relatively little time left to serve, which added to the complexity of offender management, as some still needed to take part in interventions. There was also a small, local remand population as well as prisoners serving short sentences.

6.9 There was no comprehensive or up-to-date analysis to make sure that provision aimed at reducing reoffending met the needs of the population and work was not driven by an action plan. There was a strategy, but it did not set out how the significant local challenges would be tackled. The governor's self-assessment report did not sufficiently set out the serious gaps in offender management and release planning that we found during our inspection.

6.10 It was positive that more than 500 offender assessment system reports on prisoners' risks and needs had been reviewed in the previous year. However, 61 prisoners did not have an initial assessment or sentence plan, and two thirds of them were now overdue, having exceeded the deadline for completion. Most of the assessments we reviewed were good, as they were comprehensive and analytical. However, sentence plans for long-term prisoners too often required an accredited programme, which was unlikely to be delivered for many years (see paragraph 6.19) and there was a lack of shorter-term, more achievable goals to keep prisoners engaged and enable them to progress.

6.11 The work of the offender management unit (OMU) was significantly compromised due to an acute shortage of probation officers with only 6.7 out of 16 in post. As a result, caseloads were unmanageable at about 140 prisoners each. Six extra prison-employed prison offender

managers (POMs) had been assigned to the OMU to support probation staff and co-work cases, but five of them were often redeployed to operational duties because of short staffing across the prison. Their caseloads were still high at about 75 each. There were not enough senior probation officers in post, which meant they struggled to support and supervise POMs.

6.12 Contact between POMs and prisoners was poor and, in most cases, much too limited for work to be effective, for trust to be built and high levels of denial to be addressed (see paragraph 6.22). In our survey, only 59% of prisoners with a sentence plan, fewer than at our last inspection (78%), said they understood what they needed to do to achieve their objectives. Prisoners we interviewed were sympathetic to their POMs and described them as 'overwhelmed'. The quality and quantity of key work (see Glossary) delivered by unit staff was much too weak to support sentence progression adequately.

Public protection

6.13 The prison currently released on average one or two high-risk prisoners every month. As at the last inspection, high-risk prisoners were not routinely identified or discussed at a multidisciplinary forum ahead of their release to make sure risk management plans were robust. Regular meetings had stopped in the spring and before that, they had not been well attended. We were concerned to find that preparing high-risk prisoners from the remand population and those serving short sentences for release was not considered to be part of the OMU's work.

6.14 We found examples of poor risk management ahead of prisoners' release. In one instance, a high-risk prisoner who had spent several years in prison, was due for release the following day. Liaison between the prison and his local probation office had been inadequate. There was no evidence that an appropriate multi-agency public protection agency (MAPPA) level had been considered and plans to protect the victim were unclear.

6.15 OMU's written contributions to community MAPPA meetings generally included useful details of a prisoner's behaviour in custody, but other prison departments did not provide sufficient contributions.

6.16 When we inspected, 44 prisoners were having their mail and phone calls monitored. Phone monitoring was not well staffed. There was no dedicated team, and staff allocated to this task had not been trained to identify risks and were frequently redeployed to other duties. They were sometimes unable to listen to even a sample of each prisoner's daily calls, which meant that any emerging risks could not be reliably identified.

6.17 About two thirds of the population were not allowed to have any contact with children. Initial child contact restrictions were applied swiftly and staff, such as those who checked incoming and outgoing mail, were aware of them. However, there was a backlog of 56 applications from

prisoners for contact with specific children. There was a monthly meeting to consider them, but some prisoners had been waiting well over a year for an answer. These applications for contact may have been legitimate and could have supported the prisoners' rehabilitation. The lack of probation staff to work with local authority children's services about the suitability of contact was the main barrier.

Categorisation and transfers

6.18 There were not enough progression opportunities for prisoners. Access to interventions, work, education, offender management and key work was too limited to allow prisoners to demonstrate a reduction in their risks. Many prisoners were frustrated and some described a feeling of hopelessness. Many category C prisoners had, through no fault of their own, found themselves sent to a category B prison far from home (see paragraph 3.35). There they would be subject to a more restricted regime. Some of them had originally progressed from the Isle of Wight to a category C training prison, only to return.

6.19 The prison held about 130 prisoners serving indeterminate sentences. About half were category B and they typically faced longer waits – of many years in some cases – for interventions, while recently arrived category C prisoners were prioritised ahead of imminent parole eligibility dates. There was no dedicated provision to keep them engaged in the meantime.

6.20 Despite efforts by staff in the OMU, very few prisoners were able to get a transfer to other prisons to progress or receive resettlement help. Barriers included very long journeys to other prisons and the frequent cancellation or unavailability of escort vehicles. POMs described their frustration when transfer arrangements were cancelled at the last minute, leaving prisoners disillusioned, mistrustful and less likely to cooperate. The national directive to fill empty spaces at the Isle of Wight meant that prisoners re-categorised from B to C at the prison were very unlikely to progress to a category C training prison.

Interventions

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

6.21 The delivery of interventions had been seriously undermined since the last inspection. COVID-19 restrictions had initially stopped group work in March 2020. However, progress to return the delivery of programmes to pre-pandemic levels had been too slow because of a lack of prison officers available to run a reliable regime and escort prisoners to groups. There was also a severe lack of qualified psychologists to support the programmes team. There had not been any groupwork delivery for two and a half years when we visited.

6.22 Half the population, 486 prisoners, were assessed as being in some degree of denial of their offending behaviour. Foundation and

Motivation and Engagement (M&E) were the two main interventions that could have helped them to start breaking down this barrier to treatment and prepare for an offending behaviour programme. However, nobody had completed Foundation since March 2020. M&E, for the most complex prisoners in denial, could be delivered individually, but only four people had participated during COVID-19. In the year from April 2022, plans had had to be scaled back and only 18 prisoners, rather than 50, would complete Foundation, while three prisoners would complete M&E. The provision was projected to improve considerably in the following year, but weaknesses in the regime still threatened delivery.

6.23 In our survey, only 18% of prisoners told us they had completed an offending behaviour programme, fewer than at the last inspection (41%). The prison continued to offer the same suite of accredited programmes for prisoners convicted of sexual offences – Horizon, Kaizen, Becoming New Me Plus and the Healthy Sex Programme. However, just 30 prisoners had completed one of them in the first two years of the pandemic because all delivery had been on a one-to-one basis. After a slow start, a further 49 prisoners were scheduled to complete one of the accredited programmes in the current delivery year, fewer than at the last inspection (67 completions in one year). The first group for two and half years was due to run just after the inspection, but the plans depended on available staffing and the delivery of a consistent regime.

6.24 The lack of any group work for so long meant waiting lists had increased and the recent influx of category C prisoners had added to the demand. The programmes team was managing waiting lists well and had appropriately prioritised prisoners with a parole eligibility date in the following three years, although 15 prisoners in this group still required a programme needs assessment to see if they were suitable.

6.25 The introduction of a trauma-informed unit on house block 24 was a creative response to the population's needs. There had been no national funding for the unit, and it depended solely on the efforts of some motivated staff. However, much more investment and consistent staffing was needed to make it a success. The environment was hardly any different to other units, there had not been any therapeutic groups and community meetings had been suspended. The unit was subject to the same staffing problems and regime instability affecting the rest of the prison.

Release planning

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

6.26 In the previous 12 months, 53 prisoners had been released. Many were prisoners serving short sentences and those from the remand population. However, the number of prisoners convicted of sexual offences who were released was increasing.

6.27 The prison was not resourced to provide any resettlement help. This was principally a gap for remand prisoners and those serving short sentences but also for those assessed as presenting a high risk of harm. The prison's own data showed that about one in five prisoners had been released homeless in the previous 12 months and a small number of those had been assessed as posing a high risk of harm to others.

6.28 We found examples of prisoners being released with too little support or planning. For example, during the inspection, a release planning meeting was held between the prison and the community offender manager for a prisoner with complex learning difficulties, but it was only held on the Friday before his Monday release. A POM visited the man that day at the request of remand unit staff because he was so worried about his forthcoming release. She could not allay his anxiety because she had not been briefed on the outcome of the meeting and had no access to probation case notes.

6.29 On release, no routine through-the-gate support or mentoring were available.

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 therapeutic and rehabilitative purpose of the prison was not being achieved in full.** Leaders had not developed the environment or regime in a way that sought to ensure needs and risks of the sex offender population were addressed. This was compounded by a failure to respond to the new reality of a much larger population of category C prisoners. Specialist staff shortages further worsened this situation.

2. **Over a third of officers were not available to work in the units, which limited the delivery of the day-to-day regime and led to prisoners spending too long locked in cells.**

3. **The level of recorded self-harm was very high and there had been seven self-inflicted deaths since our last inspection.**

4. **Prisoners had very limited access to work or study.** Planned access was severely undermined by poor attendance, poor punctuality and prisoners returning to their cells early.

5. **There were significant gaps in release planning for prisoners who posed a high risk of serious harm to the public.**

6. **The health provider had identified risks to service delivery and patient outcomes, but improvements did not take place quickly enough.**

Key concerns

7. **Data were not used well enough to improve outcomes.** Managers did not explore outcomes at other prisons holding a similar population, including those convicted of sexual offences and category C prisoners. They did not evaluate the impact of the education and skills curriculum to drive improvement.

8. **Many of the residential units were shabby, bleak and beyond basic repair.**

9. **Black and minority ethnic and Muslim prisoners and those with mental health problems were far more negative than their counterparts about some key aspects of their care, such as relationships with staff and safety.**

10. **Mental health and learning disability services did not provide adequate or timely evidence-based care or treatment.**

11. **There was insufficient oversight of and control over medicines creating risks to staff and patients.**

12. **Leaders had not prioritised reading or literacy.**

13. **Leaders did not make sure that prisoners could access education promptly enough to make progress towards their career aspirations.**

14. **Prison offender managers did not have enough contact with prisoners or access to interventions to help them address their offending behaviour.**

15. **There was too little support to help prisoners maintain or rebuild ties with their families and friends and no reliable resettlement help for those being released.**

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, perceptions of safety among the population were poor and management oversight of many areas of safety required improvement. The number of violent incidents had increased since the previous inspection and plans to manage perpetrators and support victims were not implemented effectively. The incentives and rewards policy was inconsistently applied leading to frustration among prisoners. Use of force had risen but oversight was reasonably good. The segregation unit was a better environment than we normally see and relationships between staff and prisoners were positive. Most prisoners had a positive experience of reception, first night and early days. Levels of self-harm remained high but care for prisoners at risk of self-harm was generally good. Safeguarding procedures were well developed. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

The prison should investigate all violent incidents thoroughly to understand the drivers of violence and implement a strategy to reduce it.
Not achieved

The incentives and rewards policy should be reviewed to ensure meaningful differences between the levels and effective oversight arrangements should be put in place.
Not achieved

Recommendations

An area should be set aside for staff to conduct interviews with prisoners in private on first reception.
Achieved

A comprehensive drug supply reduction strategy should be implemented to investigate the drivers of positive drug tests and establish a coordinated approach to supply reduction.
Achieved

Quality assurance of ACCT documents should provide more robust oversight to ensure their effectiveness.
Not achieved

Prisoners requiring a constant watch should be provided with a suitable regime and in-cell activity.
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2019, relationships between staff and prisoners remained good and there were many opportunities for prisoners to contribute to their community through peer support and representative roles. Accommodation on both sites was clean, well maintained and free of graffiti. About 100 cells remained overcrowded. Showers across the prison needed refurbishment. The application system was weak and responses to complaints were not always timely. The food was reasonably good but there were no facilities for prisoners to eat together or to cook. Oversight of equality and diversity had improved substantially in the previous six months, with evident improvements in provision for minority groups. Health care, substance misuse and social care provision was very good. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

The governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including communication of the correct medical code and calling an ambulance immediately.
Achieved

Single cells should only be used to accommodate one prisoner.
Not achieved

All prisoners should have effectively screened in-cell toilets.
Not achieved

Systems for application and redress should be managed effectively to ensure that prisoners receive a timely response.
Achieved

A memorandum of understanding should be formally agreed between the social care provider, the prison and the local authority, to ensure that social care needs are consistently met.
Achieved

Patients requiring hospital admission under the Mental Health Act should be assessed and transferred expeditiously within the current transfer guidelines.
Not achieved

Recommendations

Prisoners should be able to access their property from reception within a week of making an application.
Partially achieved

Senior managers should meet prisoner representatives regularly to ensure that their consultations with fellow prisoners lead to appropriate actions.
Achieved

Data on the treatment and conditions for prisoners with protected characteristics should be systematically collected and analysed, and action taken to address any imbalances.
Achieved

All clinical environments should comply with infection control standards.
Partially achieved

There should be a whole-prison strategy to support health promotion.
Achieved

Purposeful activity

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

At the last inspection, in 2019, time out of cell met our expectations for the majority of prisoners on weekdays and access to the library and gym was good. Leadership and management of learning, skills and work had improved significantly and were good. There was enough activity for the population, but prisoners were underemployed in a significant number of wing roles. The range of provision needed further improvement to ensure prisoners could access higher level qualifications. Teaching and learning were good and achievement rates were very high on most courses. Attendance rates were high in vocational training and education, but punctuality required improvement. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

Prisoners, including those involved in wing work, should be fully occupied and develop their employability skills by making written job applications and being aware of their job descriptions.
Achieved

Leaders and managers should expand the range of education, skills and work services to provide developmental options that better meet the needs of prisoners.
Not achieved

Wing staff should ensure that prisoners are routinely punctual at education, skills and work activities to help them recognise that punctuality is an essential skill for sustained employment.
Not achieved

Leaders and managers should ensure that prisoners' achievements in functional skills remain high.
Achieved

Recommendations

Prisoners should be able to exercise for at least an hour a day in suitably equipped exercise yards.
Not achieved

Leaders and managers should ensure that a greater number of prisoners follow and achieve qualifications in industry workshops.
Not achieved

Leaders and managers should ensure that there are enough ESOL classes to meet demand.
Not achieved

Leaders and managers should improve the quality of feedback from teachers so that prisoners always know how to improve their work.
Achieved

Leaders and managers should clarify the criteria for prisoners who wish to study distance learning programmes.
Partially achieved

Leaders and managers should ensure that teachers help prisoners to improve their spelling.
Partially achieved

Leaders and managers should identify the reasons for black and minority ethnic prisoners not achieving qualifications as well as other groups and take appropriate action to eliminate the discrepancy.
Achieved

Rehabilitation and release planning

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

At the last inspection, in 2019, most prisoners were serving lengthy sentences a long way from home. The visits provision was adequate but opportunities for families to support prisoners were missed. About 83% of the population were assessed as high or very high risk of harm. A third of the population did not have an up-to-date OASys assessment of risk or need. Contact with offender supervisors was inadequate and process driven. Public protection work was adequate but uncoordinated. Re-categorisation processes were sound and most prisoners were moved swiftly to category C conditions. The range of interventions had improved since the previous inspection. Release planning was inadequate for the small number of prisoners released from the prison. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

Prisoners should have regular face-to-face contact with an offender supervisor and an up-to-date OASys assessment to help them address their offending behaviour and to ensure that their progression is monitored effectively.
Not achieved

Prison offender supervisors should receive specific training in working as offender supervisors with sex offenders and receive regular professional supervision.
No longer relevant

Remand prisoners should be held in an establishment that can meet their needs.
Not achieved

Recommendations

The visitors' centre should be refurbished to improve services for families travelling long distances.
Not achieved

The backlog of child contact reviews should be cleared and annual reviews should take place systematically.
Not achieved

Offender supervisors should provide one-to-one opportunities for prisoners maintaining their innocence to motivate and progress them through their sentence.
Not achieved

The resettlement needs of prisoners should be assessed immediately on arrival and support provided to address those needs.
Not achieved

Appendix I About our inspections and reports

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

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

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

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

Respect
Prisoners are treated with respect for their human dignity.

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

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

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

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

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

Outcomes for prisoners are not sufficiently good.
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

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

Our assessments might result in identification of **areas of concern**. Key concerns identify the areas where there are significant weaknesses in the treatment of and conditions for prisoners. To be addressed they will require a change in practice and/or new or redirected resources. Priority concerns are those that inspectors believe are the most urgent and important and which should be attended to immediately. Key concerns and priority concerns are summarised at the beginning of inspection reports and the body of the report sets out the issues in more detail.

We also provide examples of **notable positive practice** in our reports. These list innovative work or practice that leads to particularly good outcomes from which other establishments may be able to learn. Inspectors look for evidence of good outcomes for prisoners; original, creative or particularly effective approaches to problem-solving or achieving the desired goal; and how other establishments could learn from or replicate the practice.

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

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

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

This report

This report provides a summary of our inspection findings against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 5, 2017) (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/). Section 7 summarises the areas of concern

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:

Martin Lomas	Deputy Chief Inspector
Sandra Fieldhouse	Team leader
Sumayyah Hassam	Inspector
Sally Lester	Inspector
Christopher Rush	Inspector
Rebecca Stanbury	Inspector
Jonathan Tickner	Inspector
Donna Ward	Inspector
Helen Ranns	Researcher
Isabella Raucci	Researcher
Reanna Walton	Researcher
Tania Osborne	Lead health and social care inspector
Sarah Goodwin	Health and social care inspector
Lynn Glassup	Health inspector
Nor Mohamed	Pharmacist
Dayni Johnson	Care Quality Commission inspector
Dave Baber	Ofsted inspector
Carolyn Brownsea	Ofsted inspector
Shane Langthorne	Ofsted inspector
Judy Lye-Forster	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.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.

Night sanitation system
An electronic unlocking system which provides access to communal facilities during periods of lock-up and during the night. Prisoners have to press a call button answered by wing staff to be allowed out of their cell to use the toilet.

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).

Social care package
A level of personal care to address needs identified following a social needs assessment undertaken by the local authority (i.e. assistance with washing, bathing, toileting, activities of daily living etc, but not medical care).

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

Appendix III Care Quality Commission Requirement Notice

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

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

Provider

Practice Plus Group Limited

Location

HMP Isle of Wight

Location ID

1-4969609615

Regulated activities

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

Action we have told the provider to take

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

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations (2014)

Regulation 17: Good Governance

How the regulation was not being met

The provider had identified the risks to service delivery and patient outcomes however actions to mitigate and embed service improvements were too slow:

- Despite some poor audit outcomes, few action plans had been progressed.
- Case records were not always contemporaneous; we found some specific case notes that were missing or written retrospectively up to 5 days later. Despite managers being alerted to these deficits, they had not been addressed promptly.

Pharmacy services lacked sufficient oversight and controls to ensure that medicines were managed efficiently:

- Controlled drugs (CD) were transported across both sites using a sealed bag with no security escort.
- The overall management of CDs in the pharmacy was not sufficiently robust.
- There were some expired CDs amongst in-date stock.
- Significant quantities of obsolete and patient returned CDs were awaiting destruction.
- Running balances of CDs were not audited at regular intervals.
- The controlled drug cabinets in both clinic rooms were too small to hold CDs safely.
- There was no reconciliation procedure or audit trail of emergency medicines.
- Staff reported incidents on Datix but reviews and learnings to mitigate similar events in the future were not robust.
- Patients who did not attend for medication were not always followed up in line with the provider's Local Operating Procedure.

Appendix IV Further resources

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

Prison population profile

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

Prisoner survey methodology and results

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

Prison staff survey

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

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

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

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