



Report on an unannounced inspection of

## **HMP Bullingdon**

by HM Chief Inspector of Prisons

24 October – 3 November 2022



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## Introduction

HM Prison Bullingdon, a 30-year-old facility located near Bicester in Oxfordshire, currently operates as a reception prison, holding just under 1,000 adult men. Serving courts in the Thames Valley and other parts of central southern England, the prison has a large number of unconvicted or relatively short stay prisoners: 60 or more new prisoners arrive each week and nearly three-quarters of the population are there for less than six months. As with many prisons across England and Wales, Bullingdon has grappled with the difficulties of a much reduced and inexperienced staff group.

Despite these challenges, at this inspection we found a prison that remained reasonably safe and respectful, which was consistent with our previous inspection findings in 2019. Outcomes in rehabilitation and release planning remained unchanged and were still not sufficiently good, and we judged the provision of purposeful activity to have deteriorated, to the extent that outcomes for prisoners in this area were now poor.

With the operational challenge faced with such a transitory population it was reassuring to see that prisoners were received well by the prison and given a reasonable level of support and assessment after their arrival, although there was limited extension of these assessments to prepare them to make good use of their time in the prison. In our report we describe the institution as settled but subdued. There was some useful work to reduce violence, support those at risk of self-harm and ensure reasonable governance over interventions such as use of force and use of segregation. Safety outcome measures were generally unremarkable, evidencing some encouraging trends, but fairly typical of similar and comparable prisons. There was, however, considerable lock down. Most prisoners were allowed out of their cell for as little as an hour a day, normally first thing in the morning. While we saw some mitigations, our random roll check found 58% of prisoners locked up during the main part of the working day. In general, the regime experienced even by those who had some employment was just not good enough. Our colleagues in Ofsted judged the overall effectiveness of education, skills and work to be 'inadequate', their lowest assessment.

As an institution, the prison was showing its age, with many facilities in need of investment and refurbishment. Outside areas were similarly uninspiring and far too many prisoners experienced overcrowded conditions. To the credit of leaders, work had begun to improve prisoner consultation and the deployment of peer support. There was renewed energy and investment to better support the promotion of equality, and outcomes in the provision of health care were good overall.

Staff-prisoner relationships, however, were mixed. Interactions were impeded by the limited regime, but we also observed a staff group with low expectations of, and not enough interest in, the prisoners in their charge. At the heart of this, and many other problems faced by the prison, was a chronic shortage of staff.

The prison was short of frontline staff on the wings and specialist staff in almost every department, including rehabilitative specialists, the chaplaincy, and the providers of regime activity. Leaders told us of initiatives to improve recruitment and retention among staff and work was being done to support staff well-being in an attempt to stem a high number of resignations. This work was undermined, however, by the lack of visible leadership and role modelling in frontline areas of the prison.

In the main, leaders held an honest assessment of the strengths and weaknesses of the prison and were grappling with the twin challenges of a high intensity operation and a dearth of resources. Some of their priorities needed to be more focused and measurable, but we also saw some very good initiatives to support partnership working, as well as investment in important work strands. Our report lists several priorities and concerns which we hope will assist leaders to take the prison forward.

**Charlie Taylor**

HM Chief Inspector of Prisons  
December 2022

# What needs to improve at HMP Bullingdon

During this inspection we identified 12 key concerns, of which five should be treated as priorities. Priority concerns are those that are most important to improving outcomes for prisoners. They require immediate attention by leaders 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. **Staff shortages were debilitating and had a major impact on outcomes for prisoners.**
2. **Prisoners spent too much time locked in their cells with little to do.**
3. **Leaders and managers had not designed an appropriate education curriculum that met the needs of the prison population, especially vulnerable and non-sentenced prisoners.**
4. **Leaders and managers did not identify the education, vocational training and commercial work starting points of individual prisoners.** Prisoners did not engage in meaningful education and workplace activities, which had a detrimental impact on their attitudes to learning and attendance at their lessons and therefore their ability to progress.
5. **Leaders and managers had not ensured that all prison and education staff knew how they could support prisoners to become more interested in reading and develop their reading skills.**

## Key concerns

6. **Leaders and staff had low expectations about what prisoners could be trusted to do or achieve, and didn't do enough to motivate prisoner engagement in purposeful activity.**
7. **The use of force was not always proportionate, and some staff did not do enough to de-escalate incidents before using force.**
8. **ACCT case management for prisoners at risk of harm did not always evidence targets and interventions that were tailored to their individual circumstances.**
9. **Living conditions on the main A–D accommodation were poor.**
10. **Prisoners had too little contact with their prison offender managers (POMs) and there were too few opportunities for prisoners to progress during their sentence.**

11. **Public protection arrangements were not robust enough to assure leaders that risk was managed properly.**
12. **Outcomes for remand prisoners were worse than convicted prisoners in key areas, including education, careers guidance and support for resettlement.**

# About HMP Bullingdon

## Task of the prison

A reception and resettlement prison for adult males.

## Certified normal accommodation and operational capacity (see Glossary)

Prisoners held at the time of inspection: 932

Baseline certified normal capacity: 867

In-use certified normal capacity: 867

Operational capacity: 927 (temporarily reduced from 1,112)

## Population of the prison

- 3,591 new prisoners received each year (around 300 per month).
- 164 foreign national prisoners.
- 34% of prisoners from black and minority ethnic backgrounds.
- Around 173 prisoners released into the community each month.
- Approximately a third of the population were receiving support for substance misuse.
- 192 prisoners referred for mental health assessment over past 12 months.

## Prison status (public or private) and key providers

Public

Physical health provider: Practice Plus

Mental health provider: Oxford Health NHS Foundation Trust

Substance misuse treatment provider: Inclusion

Prison education framework provider: Milton Keynes College

Escort contractors: Serco

## Prison group

South Central

## Brief history

HMP Bullingdon opened in April 1992. Its four main house blocks are divided into three-galleried units. A fifth block was added in 1998 and a sixth in 2008 – both are two-galleried units.

## Short description of residential units

Arcott – general population, including the support and mentoring unit on A3 spur

Blackthorn – general population

Charndon – general population, including the drug recovery unit on C2 spur

Dorton – general population

Edgcott – prisoners convicted of sexual offences

Finmere – the first night centre

Segregation unit

Health care inpatient unit

## Name of governor and date in post

Laura Sapwell, March 2020

**Changes of governor since the last inspection**

Ian Blakeman, until November 2019

Olivia Phelps, acting governor, November 2019 - March 2020

**Prison Group Director**

Andy Lattimore

**Independent Monitoring Board chair**

Victoria Talbot

**Date of last inspection**

July 2019

## Section 1 Summary of key findings

- 1.1 We last inspected HMP Bullingdon in 2019 and made 32 recommendations, 13 of which were about areas of key concern. The prison fully accepted 26 of the recommendations and partially (or subject to resources) accepted four. It rejected one recommendation. The establishment was not made aware of one of the recommendations and therefore did not respond to it.
- 1.2 Section 8 contains a full list of recommendations made at the last full inspection and the progress against them.

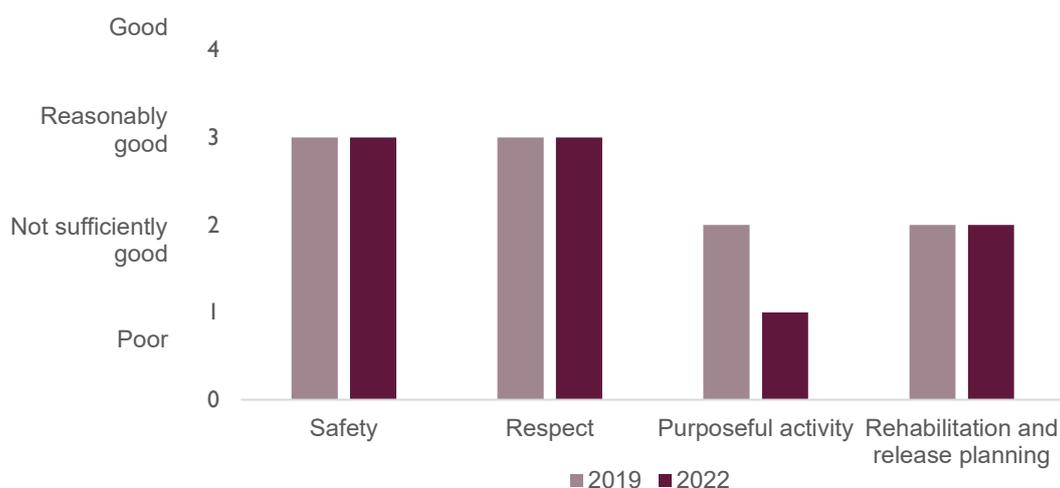
### Progress on key concerns and recommendations from the full inspection

- 1.3 Our last inspection of HMP Bullingdon took place before the COVID-19 pandemic and the recommendations in that report focused on areas of concern affecting outcomes for prisoners at the time. Although we recognise that the challenges of keeping prisoners safe during COVID-19 will have changed the focus for many prison leaders, we believe that it is important to report on progress in areas of key concern to help leaders to continue to drive improvement.
- 1.4 At our last full inspection, we made 13 recommendations about key concerns. At this inspection we found that six of those recommendations had been achieved, one had been partially achieved and six had not been achieved. All three recommendations made in safety had been achieved. In respect, one had been achieved and one had not been achieved. In purposeful activity, two recommendations had not been achieved and one had been partially achieved. Of the five recommendations made in rehabilitation and release planning, two had been achieved, and three had not been achieved. For a full summary of the recommendations achieved, partially achieved and not achieved, please see Section 8.

### Outcomes for prisoners

- 1.5 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).
- 1.6 At this inspection of HMP Bullingdon, we found that outcomes for prisoners had stayed the same in three healthy prison areas and declined in one.

**Figure 1: HMP Bullingdon healthy prison outcomes 2019 and 2022**



## Safety

At the last inspection of Bullingdon 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 remained reasonably good.

- 1.7 Reception was busy but well organised and efficient. Staff understood prisoners' risk factors and identified those who were vulnerable and might need extra support. New arrivals received a helpful document about life in the establishment and attended a good peer-led induction. Processes to assess and allocate prisoners to education and work were ineffective.
- 1.8 At the time of our inspection, the prison was well controlled. The atmosphere was settled but subdued, with most prisoners locked up for much of the day. The number of violent incidents had declined slightly since the last inspection. Incidents were investigated well. Data were used effectively to understand the causes of violence and informed a plan to improve safety. Safety meetings were productive and communication of key information was good.
- 1.9 The perpetrators of violence were managed using challenge, support and intervention plans (CSIPs, see glossary), but interventions to address and change behaviour were limited in scope and lacked creativity. There was no cohesive vision about how to motivate good behaviour, with limited rewards for those who worked hard to progress. Too many adjudications were not proceeded with, due to time delays after they had been referred to the police. This meant that some serious offences went unpunished.
- 1.10 The use of force had increased slightly since the previous inspection and its unplanned use was far higher than at comparable prisons. Staff were sometimes too quick to use force before exhausting efforts to de-

escalate situations. The quality of documentation justifying force was too variable, and although the use of body-worn cameras was improving, staff did not always turn them on. Leaders were aware of the shortcomings and were working to address them.

- 1.11 The segregation unit held some prisoners with very complex needs who were well managed by a good team of staff. Their care was overseen by a regional multidisciplinary complex case team. Most prisoners stayed in segregation for short periods and then returned to residential units. Standards of accommodation and the regime on the unit were not good enough.
- 1.12 Security arrangements were generally proportionate for the type of prison. Intelligence was used well to identify and respond to emerging threats, and multidisciplinary work, including with the police, was effective.
- 1.13 There had been two self-inflicted deaths since the last inspection; the prison was working hard to learn from these tragic events. The rate of self-harm was in line with comparable prisons and was reducing. Again, the safety team used data well to understand and take action to reduce self-harm, although the lack of purposeful activity and regime was a major factor yet to be addressed. The weekly safety interventions meeting and complex case meetings evidenced good care planning for the most vulnerable prisoners. Work had started to address weaknesses in the case management of at-risk prisoners through new robust quality assurance processes.

## Respect

At the last inspection of Bullingdon 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 remained reasonably good.

- 1.14 General interactions between staff and prisoners were often friendly and relaxed, and there were examples of very caring support for prisoners in need. However, staff had low expectations about what prisoners could be trusted to do or achieve. They did not do enough to motivate and encourage them. A shortage of staff, the limited regime and a lack of consistent positive role modelling through more visible leadership on the wings had a negative impact on relationships at Bullingdon.
- 1.15 Much of the main residential accommodation was run down and needed refurbishment. Prisoners made efforts to personalise their cells, but they were not always in good condition or well equipped. Many of the communal showers were dirty and rundown, and some of the servery areas where prisoners collected their meals were grubby. The newer house blocks were relatively clean and better presented.

- 1.16 The quality and quantity of food were adequate, but there was no communal dining or cooking facilities (with the exception of a landing on C wing). Prisoners could purchase a reasonable range of products from the prison shop and some catalogues.
- 1.17 The prisoner consultation process was in development but most prisoners were unaware of the arrangements or their effectiveness. Prisoners had little confidence in the applications system and there was no quality assurance of the process. Complaints were managed much better. Prisoners had good access to suitable private legal visit facilities, but there was no dedicated bail support officer despite the high numbers of prisoners on remand.
- 1.18 New energy and resources had led to improvements in work to promote fairness and equality. Diversity and inclusion data were used well and prisoners with protected characteristics were consulted to understand their needs. Discrimination complaints were reasonably well investigated, and there had been some recent successful special events to celebrate diversity. There were still gaps in the provision for some protected groups, but work was going in the right direction.
- 1.19 The chaplaincy was very stretched, due to staff vacancies and absences, but the team in post were working hard to cover the most essential aspects of pastoral support. Prisoners of the main faiths could only attend communal worship every other weekend.
- 1.20 An innovative, well-led and effectively governed health service was meeting most clinical need. Waiting lists for most clinics were reasonable although there were too many missed appointments, sometimes when prisoners had not been informed or unlocked. Primary care was well led and had good systems to support care. The patient experience team offered an impressive patient-facing service, improving communication and access to a range of health promotion initiatives. The inpatient unit required greater clinical focus; some rooms were very dirty and therapeutic activity was limited. Social care arrangements were generally appropriate, but staffing problems affected continuity and consistency of care. Clinical and psychosocial support for prisoners with substance misuse needs was good. Mental health provision was timely and reasonable, but with scope to improve the range of psychological interventions on offer. Prisoners assessed as needing hospital care under the Mental Health Act waited too long before being transferred.

### **Purposeful activity**

At the last inspection of Bullingdon 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.

- 1.21 Too many prisoners were locked up during the working day due to an inadequate regime and a lack of drive to get them to their allocated education or work placement. The majority of prisoners were

unemployed or had their activity sessions cancelled; their day was limited to an hour of unlock at 8am to shower, complete domestic tasks and exercise. When staffing allowed, they could spend around an hour out of cell when they collected their lunch and tea meal, but this was frequently curtailed. At weekends, few prisoners were unlocked for more than three hours a day. There was no provision of recreational equipment or games, and the exercise yards were bare.

- 1.22 Prisoners could attend the well-stocked library and had good access to large well-equipped gym areas up to three times a week.
- 1.23 Prison leaders had not used information effectively to create a curriculum that met the needs of all prisoners, particularly the vulnerable and remand population. Staffing vacancies had led to long periods in which activities did not run. This meant that too many prisoners did not attend their education, skills, and work sessions.
- 1.24 The provision of information, advice and guidance on learning, skills and work was ineffective. Leaders had devised a broad strategy for the development of reading, but had not developed a precise plan to implement it and it had not been embedded into workshops.
- 1.25 Most tutors and trainers demonstrated expert knowledge of their subjects and provided effective support to enable prisoners to develop new skills. Tutors had carefully planned to support and develop prisoners' understanding of fundamental democratic and community values.

### **Rehabilitation and release planning**

At the last inspection of Bullingdon 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.

- 1.26 Work to support contact with children and families was reasonably good. A family engagement worker from PACT (Prison Advice and Care Trust) supported many prisoners and their families. The visits provision was good and met the needs of most prisoners.
- 1.27 Leaders had identified the resettlement needs of their population and held a well-attended monthly reducing reoffending meeting. However, work across the three main departments delivering rehabilitation services was not sufficiently well coordinated and there were weaknesses in communication between the teams. This meant prisoners were not always aware of work being done to support them and in some instances were given conflicting and incorrect information.
- 1.28 The capability of the offender management unit (OMU) was significantly constrained by staff vacancies and exacerbated by the regular cross-deployment of prison officer prison offender managers (POMs). Contact

between POMs and prisoners remained poor. The prison had worked hard to make sure that most prisoners had an up-to-date sentence plan, but many prisoners were not aware they had one, which often negated their usefulness.

- 1.29 We saw some evidence of effective communication between POMs and community offender managers to manage prisoner risk on release. However, the monthly interdepartmental risk management team was still not an effective process to provide assurance that this happened for all high-risk prisoners.
- 1.30 Most categorisation reviews were completed on time, with an appropriate range of evidence considered to support the decision. However, prisoners were not routinely offered the opportunity to participate in the review, and were not always informed of the decision and the reasons why it was made.
- 1.31 There was a good range of offending behaviour programmes, but vacancies in the team meant few prisoners had completed a programme since April 2022. A few prisoners had benefited from bespoke one-to-one work from the regional psychology team, and the education team delivered a course that included some elements addressing money management and relationships. Only 19% of prisoners, however, were released to employment, education or training. Housing support was similarly limited and too many prisoners left without sustainable accommodation to go to.
- 1.32 The prison identified the resettlement needs of prisoners in their early days at the prison and produced a plan for most well in advance of their release date. The resettlement team made appropriate referrals to meet these needs, such as the contracted provider for accommodation, although this did not always lead to an address being found. Prisoners were not always kept informed about work done to help them. Support for remand prisoners was limited to resettlement advice.

### **Notable positive practice**

- 1.33 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.
- 1.34 Inspectors found four examples of notable positive practice during this inspection.
- 1.35 The regionally coordinated complex case planning meeting provided an effective forum for the management of particularly challenging and vulnerable prisoners. Discussions were multidisciplinary, and care planning was dynamic and responsive to individual circumstances. (See paragraphs 3.21 and 3.31.)

- 1.36 The prison had introduced welfare checks, where staff spoke to prisoners who had recently had court hearings, sentencings or seen a change in their family circumstances to make sure of their well-being and ask about any additional support needs. (See paragraph 3.30.)
- 1.37 There had been good work on disability awareness. A day for staff had brought in many outside agencies, such as the Paralympic Heritage Trust, National Autistic Society, Restore and Mind. A presentation to mark disability history month incorporated personal stories from both staff and prisoners who lived with disabilities. (See paragraph 4.30.)
- 1.38 The patient engagement and liaison (PEL) team provided impressive health promotion activities based on national health campaigns throughout the year. (See paragraphs 4.39, 4.43.)

## 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 Most leaders and staff worked hard to meet the demands of a busy reception prison, showing resilience in their efforts to solve some intractable problems with limited resources.
- 2.3 Staff shortages were debilitating and impacted significantly on outcomes for prisoners. A major effort was being made both locally and nationally to address this.
- 2.4 Leaders were employing various methods to improve staff well-being to reduce the high number of resignations. However, this was undermined by a lack of supportive and visible leadership in frontline areas. This was needed to raise standards and to role model appropriate attitudes and behaviour, as well as understand fully the experiences of staff and prisoners. While there were many examples of caring and supportive work with individual prisoners, the attitudes of some leaders and staff were judgmental and demonstrated to us a prevailing culture of low expectations of prisoners. Leaders at all levels had much more to do to encourage greater empathy and compassion.
- 2.5 There were appropriate arrangements to enable good partnership working in most areas. Partner organisations had also experienced staffing problems that affected outcomes for prisoners. This had led to delays, for example, in general maintenance and repairs, and an inability to provide teachers and instructors in some activity areas.
- 2.6 There was good joint working across departments, including safer custody, security and residence. Work to improve the promotion of equality and diversity was good from the regional lead down to the point of delivery. However, we had less confidence in the leadership of departments providing rehabilitation and resettlement services, where work was not well coordinated and communication was poor.
- 2.7 HMPPS leaders had invested in valuable roles, including the appointment of an employment advisor and neurodiversity lead. There was a commitment to close one wing to enable refurbishment work, although this had been delayed. There was a need for greater and quicker investment in living conditions, particularly the showers and inpatient facility.

- 2.8 The prison's self-assessment report (SAR) was honest and self-reflective, demonstrating a good grasp of the main challenges facing leaders. The priorities set out in the SAR were, however, very high level with no measurable targets for delivery, although the governor provided more detail during the inspection. The core vision articulated; that is to make sure that every prisoner's stay should be 'time well spent', was not deliverable for all prisoners due to regime restrictions and some negative aspects of staff culture.
- 2.9 Leaders in departments including safer custody and equality were making good use of data to understand their strengths and weaknesses, with evidence of planning to bridge the gaps. For example, leaders collected useful data on self-harm, reviewed it at the monthly safer custody meeting, and took actions to address the weaknesses identified. The equality manager discussed data individually with departmental managers, so that together they could understand it and plan action accordingly.

## 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 Bullingdon's reception staff managed around 60 new arrivals a week, in addition to an average of 50 court movements. Every arriving prisoner was handcuffed while walking from the escort vehicles into reception, which was disproportionate given that not all were high risk and the area was secure. Almost all prisoners now arrived with digital person escort records (PERs), most of which contained useful information about risks such as violence and self-harm.
- 3.2 Reception was busy but well ordered, and the processes we observed were carried out efficiently by friendly and welcoming staff. The reception area was clean but it remained austere. Holding rooms were not used to display photos and posters to promote the opportunities available, which could motivate and engage prisoners at the earliest opportunity. Prisoners were, however, given a useful booklet with information about prison life, which had been translated into several languages.
- 3.3 All new arrivals were routinely strip-searched and body scanned without evidence of regular risk assessment. This included prisoners who transferred in from other establishments, where they had already been subjected to this procedure on their departure. In our survey, only a minority of prisoners said that they had been offered a shower and a phone call on their first night in the prison, and we did not see staff routinely offering this to prisoners during the inspection. An Insider (peer support worker) was present in reception on evenings, but peer support was not readily available to new arrivals at all times of the day.
- 3.4 A first night officer and member of the health care team interviewed all new arrivals in private, which provided a safe opportunity for prisoners to disclose any concerns. Each prisoner was given an early days 'passport' to monitor their first days in custody. The quality of processes to identify vulnerability had improved; reception staff had a good awareness of risk and interviewed prisoners sensitively. Prisoners with a history of self-harm or who indicated vulnerability were placed on assessment, care in custody and teamwork (ACCT) case management. All new arrivals were checked four times during their first night.
- 3.5 New prisoners were located to the first night centre on Finmere unit. Cells were clean and in good order, but not all prisoners were provided

with basic items, including a kettle to make a hot drink during long hours locked up. Prisoners received a good peer-led induction which contained useful information. Vulnerable prisoners on the first night centre now received the same level of induction as others. However, the education assessments carried out on induction were less effective (see paragraphs 5.14 and 5.18). The regime on the first night centre was poor, with most prisoners receiving only one hour a day out of their cells.

- 3.6 Although new arrivals were offered packs containing vapes and basic groceries, delays in receiving their first prison shop order meant that many were unable to buy further items for over a week. This caused frustration and had led to some prisoners becoming indebted to others.

## 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

- 3.7 The majority of prisoners were locked in cells, often in crowded conditions, for most of the day during the inspection (see paragraphs 4.6 and 5.1). This contributed to the atmosphere on most wings feeling settled but subdued. Prisoners we spoke to frequently expressed frustration at the lack of purposeful activity, opportunities to socialise with their peers and difficulties getting staff to help them with things they had to do.
- 3.8 Overall rates of violence were slightly above the average for similar prisons, although they had decreased by 7% since the last inspection, and a smaller proportion of incidents were classified as serious. Assaults on staff made up around one-third of all violent incidents. The rate of such assaults had increased by 31% since the last inspection and was higher than most similar prisons, but had been on a downward trajectory over the past 12 months. Prisoner-on-prisoner assaults had decreased by around 20% since the last inspection, to a level that was about average for the type of prison.
- 3.9 Leaders had made very good use of data to pinpoint and monitor the causes of violence, identifying a lack of a consistent regime, poor communication between staff and prisoners, and debt as the key drivers of violence. Leaders used their analysis to inform an action plan to reduce violence in the prison.
- 3.10 The safer custody department investigated violent incidents routinely and promptly, usually in sufficient depth to help build a shared understanding of violence in the prison. Information was also shared at the weekly safety interventions meeting and in a useful all-staff bulletin, which helped make sure that staff across the prison were aware of emerging trends, hotspots, and prisoners of note.

- 3.11 Safer custody peer representatives had recently been recruited on each wing. Overseen by the safer custody department, they helped to prevent violence through mediation, speaking to perpetrators and victims of assaults, and assistance with day-to-day issues. This promising initiative helped prisoners to manage mounting frustrations, and engaged the hard to reach, those who were self-isolating or those at greater risk of self-harm.
- 3.12 Some perpetrators of violence were managed using challenge, support and intervention plans (CSIPs, see Glossary), but plans and targets to address and change behaviour were limited in scope and lacked creativity. This was, in part, due to the lack of interventions or purposeful activity within the limited regime, but also reflected the wider culture, which was neither motivational nor aspirational. The formal rewards scheme was not fully effective, there were no enhanced landings, recreational games or self-cook equipment. Peer work was underused and, overall, there was too little to encourage and motivate prisoners to progress.

### **Adjudications**

- 3.13 There had been just over 1,900 adjudications in the previous six months, a 45% increase from last time. This had resulted in a backlog, which leaders had addressed in the short-term by bringing in adjudicating governors from nearby prisons. However, too many adjudications were for minor rule breaches that might have been dealt with less formally through, for example, an effective incentives regime. Leaders were aware of this issue and had trained 10 segregation unit staff as adjudication liaison officers to provide advice, support and guidance to wing staff.
- 3.14 As at the last inspection, too many adjudications for the most serious offences were not proceeded with. In many cases, this was due to excessive delays after being referred to the police who then decided not to prosecute. This undermined the prison's attempts to tackle antisocial behaviour.

### **Use of force**

- 3.15 The use of force had slightly increased since the last inspection and was higher than at comparable prisons although the evidence suggested it was now falling. Due to staffing constraints, 30% of operational staff had not completed refresher training in control and restraint techniques, and many had not yet received training in the use of personal protection and the PAVA incapacitant spray.
- 3.16 The video footage that we reviewed showed that planned incidents were well-managed. However, we saw several spontaneous incidents where staff might have demonstrated better attempts to de-escalate situations, and where force was arguably used too quickly and sometimes to a greater extent than was justified.

- 3.17 The quality of documentation justifying the use of force was variable and did not always outline attempts at de-escalation or provide sufficient detail to show that force was reasonable and justified. Staff did not always use body-worn cameras or only turned them on after incidents had already escalated, although this had improved recently following a push from leaders.
- 3.18 Batons had been drawn 10 times in the previous year, although no prisoner had actually been struck by a baton. Documentation justifying their use was generally adequate. There had been one use of PAVA in the past year, which had inappropriately targeted several prisoners and affected members of staff. Leaders had investigated this incident and identified learning points.
- 3.19 Despite the weaknesses in the use of force, oversight and scrutiny were effective at identifying and addressing issues, and leaders were aware of shortcomings. A learning and development committee reviewed 10% of incidents and had offered useful feedback to staff when good or poor practice was identified. Eight staff had been dismissed for inappropriate use of force in the previous two years, indicating that action was taken in the most serious incidents. A use of force meeting identified trends and communicated concerns to staff. It had also taken some promising action; for example, the prison's neurodiversity lead had reviewed footage and provided useful information to staff when it was identified that prisoners with neurodiversity and learning disabilities were over-represented in the use of force.
- 3.20 Special accommodation had been used 27 times in the previous year for an average of 10 hours and 51 minutes, although only three of these cases had involved use of the special accommodation cell. The remaining incidents involved turning off the water or removing furniture from cells when prisoners were persistently disruptive. The sample of documentation we reviewed indicated that the use of special accommodation was appropriate and had been for as short a time as possible.

### **Segregation**

- 3.21 The prison did not routinely segregate prisoners pending adjudication, which was positive, but cellular confinement was used regularly as a punishment. Most stays were relatively short and the majority of prisoners were returned to the main residential wings, albeit without a formal reintegration plan. However, some prisoners with very complex needs were held on the segregation unit for much longer while awaiting psychological assessment or transfer to a secure hospital or another establishment. The management of these prisoners was good; staff and prisoners received support from the psychology department, and a regional multidisciplinary complex case meeting oversaw prisoner care and plans for progression or reintegration (see also paragraph 3.31).
- 3.22 The segregation regime remained very limited; prisoners received only one hour a day out of their cells to shower and spend time in the open air. Risk assessments to determine whether prisoners could associate

together had recently been introduced but no prisoner had yet met the threshold. Unit staff showed a good knowledge of the prisoners in their care. In our survey, 74% of prisoners who had spent time in the segregation unit in the past 12 months said they had been treated well by staff.

- 3.23 The communal areas on the unit were clean, but cells were dingy. Even the most recently painted cells contained graffiti, and toilets and sinks were stained. Prisoners in one of the four cells that had electrical outlets could have access to a television and DVD player, which staff used to incentivise positive behaviour. The three outside yards remained austere and bare.

## 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.

- 3.24 Physical security was generally sound, and had improved since the last inspection with the addition of a body scanner in reception and additional funds secured for further improvements. Security arrangements remained broadly proportionate for the type of prison, although new arrivals were still, without risk assessment, routinely strip searched in addition to going through the body scanner (see paragraph 3.3).
- 3.25 Leaders had focused their attention on the main security risks, which included drugs and other illicit items, and staff corruption. Intelligence was processed promptly and used well to identify and respond to these emerging threats in some cases, but not all. For example, staff shortages meant that some good intelligence was not always acted on promptly. No mandatory drug testing was taking place, which left leaders poorly informed about the actual prevalence of drug use in the prison. As a result, suspected drug misuse could not be confirmed, punished, or referred to support services. However, intelligence gained from very good joint working between the security, safety, and substance misuse teams, and good communications between the security department and wing staff, mitigated these weaknesses to some extent.
- 3.26 Although intelligence indicated that drugs were still too prevalent, there was some evidence that aspects of the prison's strategy were effective, which was borne out in our prisoner survey. Only 4% of prisoners said they had developed a problem with illicit drugs since arriving at the prison, down from 21% last time, and 31% said that it was easy to obtain illicit drugs, down from 52% last time.
- 3.27 On-site support from the police remained effective, particularly in the management of organised criminal gang activity. This was a growing issue for the prison, which now took more prisoners from courts in areas

where gang activity was more prevalent, such as Luton and Milton Keynes. Both the security and safety departments worked well with the police to understand and respond to these threats.

## 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

- 3.28 There had been two self-inflicted deaths since the last inspection. Some work had taken place to drive improvements based on recommendations from the Prisons and Probation Ombudsman (PPO) reports who investigated the deaths. While it was positive that the regional safety team regularly reviewed progress against these recommendations, not all changes were yet fully embedded. The prison now investigated all serious incidents of self-harm to identify learning opportunities.
- 3.29 There had been 830 recorded incidents of self-harm in the last 12 months, which was higher than at the previous inspection. The rate of self-harm had risen considerably during the COVID-19 pandemic, but had reduced throughout 2022 and was now in line with comparable prisons. Much of the self-harm was attributable to a small number of prolific self-harmers.
- 3.30 The prison collected useful data on self-harm, which were reviewed at the monthly safer custody meeting. Although there were few observable trends in this data, the prison had taken action to address some of the drivers, for example, welfare checks were now carried out on prisoners who had recently attended court hearings or sentencing, when the likelihood of self-harm often increased. Similarly, if prisoners had experienced a change in their family circumstances, staff made sure of their well-being and asked about any additional support needs. However, other significant causes of frustration that often led to self-harm, such as poor time out of cell and a lack of purposeful activity (see Section 5), had not yet been adequately addressed.
- 3.31 The weekly safety intervention meeting was multidisciplinary and well-attended. The meeting provided an effective forum for staff to plan and monitor the care provided to prisoners of concern, including those at risk of self-harm. In addition to this, there was a monthly, regionally led, complex case meeting to manage some of the most vulnerable and challenging prisoners; this involved good input from external agencies.
- 3.32 There were 16 prisoners being case managed through ACCT at the start of our inspection. The quality of the documents was inconsistent, with some showing a lack of individualised care planning or failing to clearly identify risks and triggers. There was also a lack of consistent case

management. Prisoners who were subject to ACCT told us that they felt well-supported by the focused care they received during reviews and from specialist services. However, they reported that day-to-day care on the wings varied, with some staff conducting observations but not engaging with them constructively. A recent robust quality assurance process had started to improve the quality of ACCT documents, but was not yet embedded.

- 3.33 There was a large team of Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners). There were still no dedicated Listener suites and sessions with Listeners continued to take place wherever a room was available, which did not always provide a suitable environment.
- 3.34 Constant supervision had been used 119 times in the last year. Records indicated that this was usually for the shortest possible time, although there were some particularly complex cases that warranted longer monitoring. There was also evidence that staff interacted with the prisoners under constant supervision, encouraging them to engage in activities like exercise. There were now two dedicated constant supervision cells, but some prisoners on under constant supervision were located in the segregation unit where there was no suitable cell to observe them safely. Instead, staff had to monitor prisoners through the observation panel, which was inappropriate.

#### **Protection of adults at risk (see Glossary)**

- 3.35 Arrangements for safeguarding adults remained well-embedded. The prison was represented at the local safeguarding adults board, and staff from the local authority dialled in to safeguarding meetings when appropriate.
- 3.36 The prison had a comprehensive safeguarding policy, which provided guidance for staff on how to identify vulnerable prisoners. This was well-understood, and prisoners were regularly referred to the weekly safeguarding meeting, which provided a useful multidisciplinary forum for planning the care of vulnerable prisoners. Minutes from this meeting demonstrated some good practice, including engagement with external agencies to plan for the care of vulnerable prisoners approaching release.
- 3.37 At the time of our inspection, seven prisoners were receiving adult social care and a further six awaiting assessment. Other prisoners with vulnerabilities who did not meet the threshold for social care were logged to follow up their care needs and any necessary adjustments.

## 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, approximately two-thirds of prisoners reported that staff treated them with respect, and 71% said that they had a member of staff they could turn to with a problem.
- 4.2 General interactions between staff and prisoners were often friendly and relaxed, and there were examples of very caring support for prisoners in need. However, some leaders and staff had low expectations about what prisoners could be trusted to do or achieve. For example, we were repeatedly told that prisoners couldn't be trusted with wing toasters and microwaves, and if they were allowed to play pool they would abuse the privilege and refuse to lock up. Most importantly, attendance at work and education was not prioritised; neither leaders of staff had joined forces to encourage and motivate prisoners to make the most of the albeit limited regime. There was a lack of supportive and visible leadership in frontline areas to raise standards and role model positive attitudes and behaviour.
- 4.3 While there were recognised staff shortages in the prison overall, residential units were better resourced than other areas. Despite this, staff often congregated in offices, leaving prisoners unsupervised on landings. In addition, the limited regime meant that prisoners were regularly locked in their cells, which hindered the development of meaningful relationships.
- 4.4 The benefits and opportunities offered through structured peer support were not exploited to their full potential. There were some traditional peer support roles, such as an Insiders, safer custody and equality representatives (see paragraphs 3.3, 3.11 and 4.25), but these were limited in numbers and many were new to their roles. The peer work scheme had not extended to wing support roles, although leaders had plans to pilot this.
- 4.5 The delivery of key work (see Glossary) to develop relationships and provide more meaningful support to prisoners had been consistently low over the past 12 months (see paragraph 6.11). In our survey, only 51% of prisoners said they had a named key worker, compared with 81% last time.

## 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 At our last inspection, we reported that too many cells designed to hold one prisoner were holding two. That proportion had increased and 32% of prisoners - approximately 300 - were now living in cramped and overcrowded accommodation.



**Single cell being used as a double**

- 4.7 The limited outside areas were reasonably well maintained with lawns and some shrubbery. Outdoor yards were bare, with no fixed exercise equipment. Both the outside areas and the yards were blighted by a persistent litter problem.



**Litter outside houseblock**



**Outside exercise yard**



**Litter on barbed wire**

- 4.8 Accommodation on house blocks A to D, where most prisoners lived, was run down and needed refurbishment. The standard and cleanliness of the shower rooms were often poor. Showers were not always properly screened, ceilings were covered in mould, and sinks and baths were unsanitary.



**Shower room ceiling**



**Shower room sinks**

- 4.9 Leaders had introduced decency checks in an effort to improve living conditions, but these were not yet effective in addressing the problems. Prisoners were able to personalise their cells, and many had made the most of their accommodation. However, too many cell toilets were extensively stained, graffiti was commonplace, and prisoners had used bedsheets as curtains and privacy screens around their toilets. Many prisoners also complained of difficulties getting some basic items, such as a kettle.
- 4.10 Accommodation on the newer house blocks were better presented. Cleanliness was much improved, and there was minimal graffiti. Relationships between staff and prisoners on these units were also more positive.

- 4.11 There was no consistent approach to distributing personal care items, and too many prisoners struggled to obtain basic toiletries. On two wings, prisoner orderlies were given responsibility for issuing toiletries and the system worked well. On other wings, prisoners had to approach staff in their office during the one-hour early morning domestic period, but the offices were often closed due to a shortage of staff and prisoners had to go without.
- 4.12 In our survey, only 14% of prisoners said cell call bells were normally answered within five minutes, against the comparator of 26%. We observed staff routinely ignoring prisoner cell bells. Some prisoners gave examples of one to two hour waits, which posed serious risk in an emergency.

### **Residential services**

- 4.13 In our survey, only 28% of prisoners said the quality of the food was good, against the comparator of 39%, and only 24%, compared with 35%, that they had enough to eat at mealtimes.
- 4.14 Menus catered for all dietary requirements. Prisoners had a choice of a hot or cold meal at lunch and a hot meal in the evenings. Breakfast packs were inadequate but portion sizes of other meals were reasonable and a good range was on offer. Few prisoners raised food as an issue with inspectors, and the catering manager attended the prison council group meeting (see paragraph 4.19). There were, however, some unnecessary delays for prisoners requiring specific diets, such as vegan.
- 4.15 Prisoners were not able to dine communally, but instead ate in their cells next to their toilets. With the exception of one landing on C wing, prisoners had no access to self-catering equipment, such as grills, microwaves and toasters. This was another missed opportunity to develop a community ethos and demonstrate a level of trust and respect fundamental to establishing a more respectful culture.
- 4.16 The main prison kitchen was clean with adequate equipment and excellent storage facilities. Supervision at mealtimes was adequate, but there was poor adherence to some basic food hygiene standards. Prisoners serving food did not always wear the correct personal protective clothing and wing serveries were not always cleaned before evening lock-up. Staff had not been completing basic food hygiene procedures, such as servery checks and food temperature control, for several months.
- 4.17 Most prisoners could purchase a reasonable range of products through the prison shop, although increased costs had made some items less affordable, particularly for those who did not receive money from family. A small range of catalogues were available for personal orders, but administration staff vacancies had meant delays in receiving orders and prisoners were often unaware if their order had been processed.

## **Prisoner consultation, applications and redress**

- 4.18 There were many strands of consultation with prisoners, with a varying degree of effectiveness. Leaders had led prisoner forums on issues such as mental health, induction, the incentive scheme and the resettlement provision. There had also been a safety survey, but this was limited to mainly two wings and had a minimal response rate – approximately 15%.
- 4.19 The prison council had restarted in early 2022, but they had only met three times which was not regular enough to be effective. While the meeting covered a range of topics, there was little evidence that discussion had led to positive changes. Staff from key departments were frequently absent and prisoner representation was disorganised, so their attendance was ad hoc. Prisoners did not see a record of the meeting and most were unaware of consultation arrangements.
- 4.20 Prisoners had little confidence in the applications system. Application forms were available on the wings, sometimes by request, but many prisoners reported long delays in receiving replies (if any response was received at all). The prison had taken action to alleviate this by separating the collection boxes for on-wing applications and off-wing, but application forms were not logged, tracked or monitored to completion, which undermined the process, and there was no formal quality assurance.
- 4.21 The number of complaints had remained consistent with 2,542 submitted over the last 12 months. While there was better monitoring of complaints than applications, data provided at senior management meetings indicated that 18% were not responded to on time. The highest number of complaints related to residential problems and the issue of prisoner property. It was not clear how this information was used to improve the provision. In the complaints we sampled, responses were reasonable. Quality assurance was not carried out sufficiently regularly, but we saw some good examples of effective oversight from earlier in the year.
- 4.22 There was good access to suitable private legal visit facilities, which were complemented by well-used video conferencing suites. There was no dedicated legal services officer, despite the high remand population. A range of legal texts were available in the prison library, but there were no dedicated laptops or computers for prisoners to access information on legal rights.

## 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

- 4.23 Leaders had given priority to the promotion of equality in the last year, and the results were showing in improved outcomes. A management post had been created, together with a full-time administrator, and the impact was clear. The strategic meeting on diversity and inclusion (D & I) was now monthly, led usually by the governor or deputy governor, and was more effective, partly because the data it received were much richer than before. The manager discussed data with departmental managers so that it was interrogated and action planned in response. A well-designed monthly D & I newsletter was distributed around the prison, and there were presentations to prisoners on their in-cell TVs.
- 4.24 There were growing reports of alleged discrimination incidents through discrimination incident reporting forms (DIRFs), which were investigated adequately, but this burden fell too heavily on the D & I manager. About 15 middle managers had been trained to do DIRF investigations, but they were not yet doing them.
- 4.25 There was one prisoner peer worker for D & I, although he combined this with other tasks. Leaders had decided to incorporate D & I issues into the wider remit of peer mentors, but there was not yet sufficient peer advocacy and support for equality work on the wings.
- 4.26 There had been a good start in bringing members of specific minority groups together, with focus groups held for each of the statutory protected characteristics, and also for other groups – such as a faiths forum, a focus group for people with mental health issues, and a meeting of young black prisoners. These had not yet settled into the intended regular quarterly cycle, and not all the senior managers allocated for each protected characteristic were yet actively pursuing this responsibility.
- 4.27 There had been some events to celebrate ethnic diversity, such as 'cook-offs' for Asian and for black Caribbean prisoners, and a good cultural event for members of the Traveller community. The forums for prisoners of black and ethnic minority heritage were effective and had led to some changes.

## Protected characteristics

- 4.28 The large number of foreign national prisoners were not yet given enough support. In our survey, only 39% of foreign nationals said that staff usually treated them with respect, compared with 73% of British prisoners, while only 29%, against 76%, said there was a member of staff to whom they could turn with a problem. Some written material, such as ACCT and CSIP guidance, had been translated into the main languages, and the HMPPS induction information book had recently been issued in eight languages. Staff were not, however, making sufficient use of professional telephone interpreting to communicate with non-English speakers. The Home Office immigration staff based at the prison gave a good service and were very accessible on the wings. Seven people were being held at the prison under immigration powers alone.
- 4.29 There were several wheelchair users and prisoners with other mobility issues, who were generally given good support. This was especially the case in the inpatient unit and on E wing, where several were located on the ground floor of one spur, with paid carers or 'buddies' and good mutual support. Several departments were involved with the care of disabled prisoners, including the safer custody team (who dealt with physical adjustments to cells etc. and evacuation plans), the equality team, the patient liaison team and clinical health care staff, and the social care staff provided by the county council. A few prisoners felt there was insufficient coordination, although they praised the efforts of some wing staff.
- 4.30 There had been some good work on disability awareness. A day for staff had brought in many outside agencies, such as the Paralympic Heritage Trust, National Autistic Society, Restore and Mind. For disability history month, a presentation had been compiled drawing together personal stories from both staff and prisoners with disabilities. A neurodiversity support manager had made an energetic start in the role, and took an active part in multidisciplinary approaches; for example, she was working intensively with a frequent self-harmer, in liaison with a programmes team member.
- 4.31 A senior manager led on work with young adults, and had produced an imaginative strategy, although this was awaiting staff resources to put it into practice. Forums had begun to trigger some small changes. Forums for older prisoners had similarly led to provision of some small aids, such as magnifier lenses, but there were no activities, such as gym sessions, tailored to the over-50s. Care-experienced young adults had been well supported, and two specialist prison offender managers (POMs) were shortly to be trained to take over this role.
- 4.32 Leaders had responded to apparent under-disclosure by LGBT people by giving training to reception and first-night staff, and the number disclosing had since grown. The forums for this group were well attended, and Pride had been given a high profile. The transgender prisoner currently resident said that she was given appropriate

opportunities and support, with some deficits in the provision of make-up and clothing. Leaders were actively seeking ways to meet these needs.

- 4.33 A member of staff who was a veteran took care to speak with all new arrivals who identified themselves as having served in the forces. He coordinated some good events, such as Armed Forces and Remembrance days, as well as facilitating monthly visits from SSAFA, the veterans' charity, which was also the gatekeeper for other related charities.

### **Faith and religion**

- 4.34 The chaplaincy was very stretched, with vacancies and other periods of staff absence. There was under-representation, for various reasons, of the Muslim, Anglican, Free Church, Hindu and Buddhist faith groups in the team, and currently no Catholic priest was available to celebrate Mass. In the absence of the managing chaplain, a team member was coordinating the team and he and one Anglican chaplain were covering the statutory duties as best they could. They were able to provide pastoral support to those in clear need, including those on ACCT, but they were unable to see all those preparing for release.
- 4.35 Prisoners from the three most widely represented faith groups – Muslims, Catholics, and Church of England and other Christian denominations – could only attend communal worship every other weekend. The reasons for this situation, which we see in very few other prisons, were not clear. It was variously attributed to chaplaincy or operational staffing levels or security considerations, and the view that if one of these groups could only worship fortnightly, the same should apply to the other two. Since none of these reasons seemed compelling, restoration of weekly access to worship should be a priority.
- 4.36 In the circumstances, it was commendable that the positive perceptions of faith provision in our prisoner survey were comparable to similar prisons and to our previous inspection. Limited weekday faith activities were provided, and the worship spaces were suitable for their purpose.

### **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.

- 4.37 The inspection of health services was jointly undertaken by the Care Quality Commission (CQC) and HM Inspectorate of Prisons under a memorandum of understanding agreement between the agencies. The CQC found there were no breaches of the relevant regulations.

## Strategy, clinical governance and partnerships

- 4.38 Practice Plus Group (PPG), Health in Justice was the lead provider of health services, supported by other subcontracted services, including Oxford Health NHS Foundation Trust who delivered mental health support, and Time For Teeth who offered dental services. Partnership working was positive with good arrangements to monitor and account for service delivery. Clinical activity was governed effectively. Incidents were well managed and lessons used to inform service improvement. Recommendations from Prisons and Probation Ombudsman (PPO) investigations into deaths in custody (see paragraph 3.28) were considered thoroughly and acted on.
- 4.39 Health services were well-led and had developed strong administrative functions to support patient care. The model of care was supporting two distinct planned and unplanned care pathways facilitated by an innovative skill mix that included dietetic and social work input. This was underpinned by a patient engagement and liaison (PEL) team whose remit was to improve patient communication and access to a range of health promotion initiatives.
- 4.40 Health care staffing was under pressure with several vacancies and regular use of agency staff, who were not always consistent. This meant that activities had to be prioritised using staff redirected from their regular duties. Despite these pressures, staff had delivered the expected 24-hour core provision, except during August 2022 when some clinics had been curtailed. Some prisoners expressed frustration about health care provision, but staff we met treated patients with respect and were motivated to provide the best service possible. Training and professional development for staff were reasonable, but supervision arrangements were less robust. Further training had been provided and new structures established to facilitate this, and most staff we spoke to described being well supported.
- 4.41 Clinical records we sampled were of an appropriate standard. Clinical areas were generally clean and spacious, but not all complied with infection prevention and control standards. Arrangements to respond to health emergencies were effective, with first-responders trained to immediate life support level. Equipment standards, including checking arrangements, had recently been refreshed, but some use-by dates for emergency medicines had expired, although this was immediately addressed once pointed out.
- 4.42 Health complaints were well managed with most dealt with initially face to face. The written responses to concerns and formal complaints that we sampled were clear, answered the issues raised and indicated how these could be escalated if the patient remained dissatisfied. There were opportunities to make better use of the PEL team to resolve concerns at an earlier stage and trigger access to health care appointments, which health care leaders acknowledged.

## **Promoting health and well-being**

- 4.43 There was still no prison-wide health promotion strategy or action group to monitor progress. However, PPG had an organisational-wide approach to health promotion, with the PEL team offering an impressive patient-facing service that took the lead on planning and running health promotion activities based on national health campaigns throughout the year. These included a suicide prevention forum and working with the Hepatitis C Trust to raise awareness about screening and treatment.
- 4.44 Health promotion literature was available in the health care centre and across the prison, but was not displayed or easily accessible in languages other than English. An eye-catching monthly newsletter was used to inform prisoners of health promotion initiatives. Telephone interpreting services were available to facilitate health appointments when needed.
- 4.45 The PEL team also saw every prisoner to complete a well-being assessment during their first week and before release to resolve any issues affecting their well-being, which was positive. The team was progressing with the autumn COVID-19 and influenza vaccination programmes. Other immunisations and vaccinations were offered, but uptake was low.
- 4.46 A range of prevention screening programmes were available, including for bowel cancer. Prisoners were screened for sexual health and blood-borne viruses, and visiting specialists were accessible to support treatment. Barrier protection was available from health staff.
- 4.47 Nutritional advice and support for a wide range of conditions, including diabetes, high cholesterol and weight management, were provided by the dietician. Smoking cessation clinics had been on hold for a few months due to staffing issues but had recently restarted.

## **Primary care and inpatient services**

- 4.48 Nursing and substance misuse staff screened all new arrivals and ensured referrals were made to other services as required. The high number of arrivals meant an exceptional safety assessment was occasionally used when there was insufficient time to fully screen all prisoners. A secondary health assessment took place within seven days, usually after three to four days.
- 4.49 The service provided 24-hour nursing cover. Ongoing staffing challenges, including availability of agency staff, sometimes meant work allocations were changed at short notice. GP clinics were available Monday to Thursday. GPs also provided clinics for new arrivals and regularly saw patients in the inpatient and segregation units. A range of nurse clinics including for triage, wound care and vaccinations were available Monday to Friday, as well as on wings at weekends.
- 4.50 The planned and unplanned care pathways worked reasonably well, and emergency care practitioners responded to more urgent need, such as

suturing patients with self-harm injuries. Urgent GP appointments were available during each clinic and the waiting times for routine services were generally short, with a 14-day wait for a routine GP appointment. Our survey indicated prisoner frustration with primary care access. We found that notification of appointments was unreliable and there was evidence that patients had been unable to attend them, which was also leading to clinical time being wasted.

- 4.51 Patients made paper health care applications, which were regularly collected and directed to the appropriate team for review. The triage of primary care applications was inconsistent and did not always result in patients receiving the most appropriate appointment. This was acknowledged by the provider who agreed to revise the triage process.
- 4.52 Patients with a long-term condition, such as asthma and hypertension, were generally well supported by a lead nurse and two specialist nurses who managed clinics and organised timely reviews. Access to visiting professionals, who included a physiotherapist, podiatrist, optician and dietician, was reasonable. Some health care appointments were conducted using telemedicine, which reduced demand for external hospital appointments. Hospital appointments and escorts were well managed, but too many were cancelled due to failings with the contracted taxi service.
- 4.53 Patient records clearly described the treatment provided, and we saw evidence of care plans used effectively to guide the treatment patients received.
- 4.54 The 24-bed inpatient unit accommodated patients with physical, social care and mental health needs. The unit needed an improved clinical focus as there was no clear admissions policy, although admissions were overseen by health care. The physical environment was tired and needed an overhaul; some patient side rooms were extremely dirty. There was no therapeutic regime, structured activities or access to off-ward facilities. Assigned care staff were taken from the unit too frequently due to staffing shortages elsewhere, which meant that patients frequently waited too long to receive their planned care and general regime, although we were told staffing on the unit would now be ring-fenced to prevent this.

### **Social care**

- 4.55 A memorandum of understanding between HMP Huntercombe, HMP Bullingdon, Practice Plus Group and Oxfordshire County Council detailed how social care support should be identified and delivered. The local authority attended partnership board meetings and formal safeguarding meetings regularly to review arrangements.
- 4.56 The health care team coordinated all referrals and provided all direct care, with an in-house social worker ensuring assessments were undertaken promptly. Responses to referrals were timely, but it was unclear how frequently reviews of care took place. At the time of the inspection, five prisoners on the inpatient unit were receiving a care

package involving intimate care, with five other prisoners on E wing having to visit the inpatient unit to use the accessible shower and bath because amenities on their own wing were inadequate. Care on the unit was generally good, but could be delayed by regime curtailment, although prisoners told us they appreciated the support provided.

- 4.57 None of the cells on E wing could accommodate a wheelchair. Several prisoners expressed frustration about their living environment and the time taken to access and make use of inpatient amenities, which often occurred during general association time. Peer carers supported some prisoners with non-personal care needs, which the prisoners valued. However, training provision for peer carers was unclear and needed to be resolved. Improved access to cells and other basic amenities for prisoners with disabilities on E wing would also enable them to maintain their independence.

### **Mental health care**

- 4.58 Oxford Health NHS Foundation Trust provided integrated mental health services through a new contract which had commenced in October 2022. Despite these changes - and ongoing staffing pressures - provision of mental health support was prompt and reasonable, although there was scope to improve the range of psychological interventions on offer.
- 4.59 Effective health screening at reception ensured that prisoners needing support were directed to mental health services promptly. Referrals could also be triggered by officers, other health professionals and directly by prisoners. The team was available seven days a week (8am-5pm) and consisted of psychiatry, mental health nurses, a learning disability nurse, occupational therapist and primary care therapists, but with vacancies for nurses, a social worker and psychology, which was affecting caseloads. A duty worker was designated to respond to urgent need and attend all initial ACCT reviews. The team operated a stepped care model, ranging from self-directed care through to complex case management. All new referrals were triaged by the primary care mental health team and an assessment undertaken within five days. These cases were discussed at the multidisciplinary team and, if accepted on the caseload, allocated an assigned practitioner, depending on need.
- 4.60 Caseloads were around 15-20 per practitioner, with 19 patients with severe and enduring mental illness supported through the care programme approach. Care included one-to-one support and group work. Although psychological interventions such as cognitive behavioural therapy and eye movement desensitisation and reprocessing psychotherapy (EDMR) were available, lower intensity support was more fragmented and complex psychological input limited due to vacancies in the team.
- 4.61 The team had local clinical governance arrangements incorporating sound assurance and accountability. The records we sampled showed clear assessments, detailed care plans and regular therapeutic contacts. Staff accessed appropriate training and regular supervision. Officers,

however, only had access to mental health awareness through ACCT training, although the new provider had specific packages it intended to roll out. In addition, more regular support to the staff in the segregation unit should be developed to better support some of the complex prisoners held there.

- 4.62 Pre-release arrangements were good. Patients were seen six weeks before release with the team able to refer prisoners to the Reconnect programme (see Glossary) if deemed appropriate. However, patients needing specialist care routinely waited too long to be transferred to hospital under the Mental Health Act. This directly affected their treatment and potential recovery.

### **Substance misuse treatment**

- 4.63 A drug strategy and action plan informed joint working. In our survey, only 31% of prisoners said that illicit drugs were easy to access in the prison compared with 52% at our last inspection. Substance misuse services were good overall and prisoners were positive about the support provided, mirroring feedback given to the team that had influenced service delivery.
- 4.64 Inclusion, from Midland Partnership NHS Foundation Trust, provided drug and alcohol psychosocial interventions, and PPG provided clinical services. The teams were well-led and worked in an integrated way. We observed skilled and caring staff who received regular supervision and appropriate training.
- 4.65 New arrivals with drug and alcohol problems received thorough assessment and support. Clinical observations required for patients detoxing from alcohol or drugs were completed during the night by primary care nurses on the induction or inpatient unit. We were concerned, however, that prisoners who went to the segregation unit following reception screening (such as those suspected of having ingested drug packs before arrival at the prison) were not having the required overnight observations undertaken by clinical staff; this posed risk and needed to be addressed.
- 4.66 At the time of the inspection, 145 patients were on opiate substitution therapy with most on maintenance doses, which was appropriate. Prescribing was flexible and in line with national guidelines. Clinical management was effective, and five-day, 28-day and 13-week reviews were completed with Inclusion.
- 4.67 Inclusion supported 298 prisoners, approximately a third of the population, through a range of one-to-one support, workbooks and group sessions. A four-step programme, building the foundations for sustained recovery, had recently started and had been well received by participants. Inclusion staff saw prisoners suspected of involvement in illicit drug /hooch use, providing harm minimisation information and support.

- 4.68 The drug recovery unit supported prisoners effectively to remain drug free; further developments were being explored but depended on prison staffing levels. Alcoholics Anonymous and Narcotics Anonymous held regular meetings to support abstaining prisoners, although the lack of peer recovery champions was a gap.
- 4.69 Pre-release planning was good, focusing on relapse prevention, harm minimisation and continuing treatment if required. Community drug teams now accepted psychosocial referrals, which was positive. Naloxone (to reverse the effects of opiate overdose) was offered on release where appropriate.

### **Medicines optimisation and pharmacy services**

- 4.70 The in-house pharmacy was well managed and supplied medicines promptly. Most medicines were supplied on prescription with an appropriate labelling and dispensing audit trail. Prescribing and administration was completed on the SystmOne clinical IT system. Most patients had an in-possession risk assessment completed on arrival, but these were not always reviewed at appropriate intervals with the reason for deviation from the in-possession risk assessment not always recorded. More patients could be considered for full in-possession rather than weekly medication. Patients leaving the prison were generally given at least a seven-day supply of their medicines.
- 4.71 Medicines were administered twice a day on the wings by pharmacy technicians and nurses. There were limited provisions for midday or night-time administrations, and some medicines were not prescribed in accordance with therapeutic efficacy. Staff followed up patients who missed medicines. Officers did not supervise the medicines queues adequately, and crowding at the medicines hatch resulted in a lack of privacy and opportunities for diversion.
- 4.72 There were no pharmacy-led clinics but realistic plans to commence them soon, with advice about medicines provided at the hatch by the technicians and nurses.
- 4.73 Medicines were generally stored appropriately in the pharmacy and on the wings. Some wings did not store in-possession medicines separately from those not in possession, which could increase the risk of errors. Controlled drugs were well managed and audited at regular intervals. Medicines were stored and transported through the prison securely. Cold-chain medicines were kept in suitable fridges, which were continuously monitored.
- 4.74 Some medicines could be supplied without the need to see a doctor, with stocks of medicines used to treat minor ailments kept on the wings. An out-of-hours cupboard contained a range of medicines, including antibiotics and pain relief. However, these were not always supplied in packs printed with the required dosing and safety information, which meant that patients might not know how to take them safely. There was limited monitoring and auditing of stock levels in the out-of-hours cupboard.

- 4.75 The pharmacy recorded and reviewed any errors to learn from them. Written procedures and protocols were in place. Members of the pharmacy team attended monthly medicines management meetings with colleagues from other areas of the health care team. The pharmacist clinically reviewed all prescriptions to provide support and oversight. The prescribing of some abusable medicines and high-cost medicines was monitored.

#### **Dental services and oral health**

- 4.76 The waiting time for a routine dental appointment was around 12 weeks, which was too long, although this was much improved from the waiting time of 40 weeks only three months previously, which was due to the failure of the X-ray machine, which had since been replaced. Extra sessions were being provided to bring the waiting times down to a more manageable level.
- 4.77 The number of patients not attending their appointments remained high at around 29%. However, the dentist was proactive and engaged with patients by visiting wings to check if their needs had changed and offering advice. The clinical time was used to good effect by offering more treatments to patients who had attended their appointment.
- 4.78 The dentist and dental nurse promoted oral health and provided information on brushing technique and diet. The care records we reviewed were detailed and described the treatments offered and provided. The dental surgery was adequate and all necessary equipment was well maintained. Decontamination procedures and infection control standards were met, with an air purifier in use.

## 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 Prisoners working full-time could access 7.5 hours a day out of their cell on weekdays. The large number of prisoners who were not in work were out of their cell for only an hour at 8am. The timetable allowed for up to an hour at lunchtime and teatime when prisoners collected their meals, but this time was frequently curtailed due to staff shortfalls and prisoners were only out for only five minutes to collect meals from the servery. In our prisoner survey, 40% of prisoners said that their time out of cell on a weekday was confined to less than two hours. This was better than the 63% who were experiencing limited time out of cell in similar prisons, but worse than the 21% reported at the last inspection. We were told that prisoners could have up to a maximum of three hours out of cell each day of the weekend. In our roll checks during the main work periods, on average 58% of prisoners were locked in their cells. For almost all prisoners, the 8am to 9am period was the one opportunity for a shower and exercise. Although the time out of cell was insufficient, the morning slot was provided consistently.
- 5.2 There was no access to recreational equipment such as pool tables and table tennis. The exercise yards were of a good size, but were completely bare apart from two benches on each. Other than the traditional gym and library provision, there was little focus on providing enrichment activities to occupy and motivate prisoners.
- 5.3 The library was attractive, bright and well organised. The facility was well stocked and had a range of good promotional displays. The staff were enthusiastic in commending reading and methods of information-gathering to prisoners attending. In our survey, 64% of prisoners said they could visit the library at least weekly, which was better than comparable prisons and the previous inspection, although many prisoners continued the COVID restrictions habit of ordering books, which the orderlies delivered to the wings. The new lead librarian was exploring ways to increase use of the library.
- 5.4 The librarians worked closely with the Shannon Trust literacy programme (see paragraph 5.15-16) and Storybook Dads, enabling prisoners to record a story for their children (see paragraph 6.2). They also recruited a steady flow of prisoners for the 'Reading ahead' challenge.

- 5.5 The gym was fully staffed, and its facilities were large, well equipped and well used, including an artificial grass pitch. Prisoners could go to the gym three times a week. Each wing attended at a separate time, which meant that clubs and squad sessions for specific sports with membership from across the prison could not be held. Under twinning schemes, coaching by Oxford United Football Club had resumed, and rugby coaches from RAF Brize Norton were due to return for regular sessions. Some non-accredited learning, such as a 'healthy living' course, had been delivered, but there were not yet any slots for older prisoners, for example, and almost all gym use was for recreation rather than to gain qualifications.

## 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.

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

Overall effectiveness: inadequate

Quality of education: requires improvement

Behaviour and attitudes: requires improvement

Personal development: requires improvement

Leadership and management: inadequate.

- 5.7 Prison leaders had not effectively designed and planned the curriculum to meet the individual needs of all prisoners. For example, vulnerable prisoners were not engaged in any education or work activities. Furthermore, non-sentenced prisoners undertook activities which did not meet their career interests. This had led to prisoners not accessing and

benefiting from meaningful education and work, and being locked up for significant periods of time.

- 5.8 Significant staffing vacancies had led to sustained closure of education and vocational training. As a result, prisoners could not access courses such as barbering, mathematics, information and technology, and English for speakers of other languages (ESOL) qualifications for several months.
- 5.9 The quality of education, skills and work had not improved sufficiently since the last inspection and was not yet good. Leaders had only fully achieved one of the four recommendations made at the previous inspection.
- 5.10 Prison leaders had not used management information effectively to shape their curriculum priorities and strategies. For example, managers did not accurately know how many prisoners needed to improve their English and mathematics skills or which prisoners had any additional learning needs and who were non-readers. Leaders had plans to access more detailed information to help their planning, but this was not in place yet.
- 5.11 Prison and education leaders had not ensured that there were sufficient activity spaces to meet the needs of the prison population. Just over a quarter of the prisoners were unemployed at the time of inspection. Furthermore, leaders had not maximised the spaces available due to delays in risk assessment of the prisoners. For example, in some instances short-sentenced prisoners had to wait between six and 12 weeks to confirm their risk level and whether they could attend vocational and contract workshops.
- 5.12 Education and prison leaders had not made swift progress on improving the areas for development that they had identified. For example, managers had not taken any actions, until recently, to ensure that non-sentenced prisoners received appropriate initial advice and guidance. As a result, it was too early to judge the effectiveness of the actions taken.
- 5.13 The allocations process was inefficient. A significant minority of prisoners had waited too long to access their chosen work activities. For example, prisoners who wanted to attend warehousing and distribution workshops were asked to join breakfast packaging workshops to prioritise meeting the prison contract obligations with employers. Furthermore, prisoners who had previous mathematics qualifications were expected to attend low-level mathematics functional skills lessons. As a result, prisoners' attitudes to learning and vocational training were poor.
- 5.14 Staff did not introduce education opportunities to prisoners effectively. They did not clearly explain the purpose of induction. Too much emphasis was placed on prisoners completing documents without checking whether they were able to read them.

- 5.15 Leaders had developed an ambitious strategy for the development of reading. They had a clear aim to improve the reading ability of non-readers, and to encourage reading for pleasure within the wider prison population. They had worked closely with the Shannon Trust coordinators, the library provider and the prison education framework provider in the development and implementation of their reading policy.
- 5.16 The recent appointment of the prison's Shannon Trust coordinators had secured a good number of newly trained reading mentors. They were supporting 15 prisoners to take the first steps in reading, but it was too early to identify prisoners' progress into more formal education or English functional skills qualifications. Shannon Trust mentors were rightly frustrated as leaders and managers did not facilitate them to meet non-readers in a suitable learning environment. This was limiting the progress of prisoners in their reading. English teachers were trained in phonics and supported prisoners well in class. However, leaders had yet to encourage reading in workshops and industries.
- 5.17 Most prisoners with additional learning needs who attended education, vocational and contracts workshops received effective support from their tutors and instructors. However, lack of individual support for prisoners with very complex learning needs reduced their progress in the lessons for this group.
- 5.18 Prisoners received poor quality careers information, advice and guidance. Advisors conducted short interviews with prisoners to identify past work experience and career aspirations. However, they did not consistently receive or access the information needed to provide prisoners with the most appropriate guidance promptly. As a result, prisoners did not have effective education and work plans. Furthermore, a significant minority of prisoners were not placed on the most appropriate courses or activities to support their intended destinations or career aims.
- 5.19 Most instructors in workshops and industries did not assess the starting points of the prisoners effectively. For example, in the packaging workshops, prisoners were unable to explain what employability skills they had developed by completing the work activities. As a result, they were not able to evidence the progress they made in their work activities.
- 5.20 Prison leaders had developed a curriculum for the sentenced prisoners which offered them appropriate employment pathways. They had used relevant local labour market information and considered the demographics of their convicted prison population to design the curriculum. Furthermore, they had purchased bespoke training to meet the needs of employers and key stakeholders, such as forklift truck and warehousing training to support recruitment for local employers. This helped some prisoners to fulfil their personal and career goals upon release.
- 5.21 The main prison education framework provider provided a well-designed subject content for most of the educational and vocational areas that were running. In English, ESOL and art, teachers delivered well-planned

learning activities within the very tight timescales agreed with the prison. Within mathematics, non-specialist staff focused too heavily on assessment and the completion of past examination papers. Due to staffing shortages, some subjects did not have specialist teachers and other curriculum areas were not running. As a result, the progress of prisoners from their starting points was not consistently strong.

- 5.22 Most teachers and trainers demonstrated expert knowledge of their subjects and provided effective support to a small proportion of prisoners attending, which enabled them to develop new skills. For example, English teachers had the teaching craft and experience to be able to adapt the curriculum to the starting points of the prisoners.
- 5.23 Prisoners who attended their education and vocational training valued the skills they were learning in most workshops and could communicate the progress they were making. They could state which of the skills they were developing could be useful for in the future, even though it was not going to be their chosen pathway.
- 5.24 Too many prisoners withdrew from their qualifications prior to completion. For example, too many prisoners who started their level 1 English and mathematics courses did not successfully complete. Furthermore, few prisoners achieved their mentoring qualification, which in turn curtailed the quality of the support that they were able to provide their peers in learning activities.
- 5.25 Within industries, prisoners used equipment that met industry standards. For example, in the laundry, prisoners were able to use the industrial washers and driers and obtain relevant qualifications that meet the requirements of local employers operating in this sector.
- 5.26 Attendance at education and vocational workshops was generally low, but it was high in commercial contract workshops. However, too many prisoners did not arrive at their sessions punctually. Prisoners were respectful and demonstrated positive relationships with their peers and tutors. They were polite and refrained from using derogatory or aggressive language. This created a calm and positive environment, which was conducive to learning and work activity.
- 5.27 Prisoners who attended their sessions felt safe within education, training and work and looked forward to their attendance. Prisoners had not reported any bullying, harassment or discrimination while attending work.
- 5.28 A minority of prisoners who took part in activities within industries developed their confidence and resilience. For example, in textiles and laundry, they received appropriate training on the use of equipment. This enabled them to move easily around the different tasks within the workshop. As a result, these prisoners felt better prepared for future work opportunities.
- 5.29 Tutors in education carefully planned lessons to support and develop prisoners' deeper understanding of fundamental democratic values. Tutors missed opportunities for prisoners to identify and develop

employability skills. As a result, prisoners in industries missed valuable chances to develop the skills that they needed.

- 5.30 Prisoners who attended education and vocational training received higher pay to encourage them to attend their sessions. However, due to severe shortage of staff and restricted regime time, prisoners did not attend these sessions frequently enough.

## 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 In our survey, only 22% of respondents said that staff had encouraged them to keep in touch with family and friends. Specific work to support prisoner contact with children and families was led by a custodial manager and what we found was reasonably good. The prison had successfully hosted five extended family day visits during the year. The published family strategy lacked sufficient ambition as it did not include any priorities, and had not been updated to take account of changes in the family support provided by PACT (Prison Advice and Care Trust), who no longer delivered courses on subjects such as parenting. The prison was tendering for a new provider and planned to introduce a new course soon.
- 6.2 Library staff supported prisoners to record Storybook Dads messages to send to their children, and in the previous six months 30 prisoners had used this facility (see paragraph 5.4).
- 6.3 A family engagement worker from PACT met new arrivals, and held a caseload of prisoners who needed support with family court matters or re-establishing family links. They also met family and friends at the visitors' centre to book them in for their visit. With old furniture and no secure storage, the centre was in need of refurbishment to create a more welcoming area.



#### **Visitors centre**

- 6.4 Prisoners had good access to social visits. Remand prisoners could receive three visits a week, and sentenced prisoners four a month, with an additional visit for those on the highest level of the incentives scheme. In our survey, more prisoners than at similar prisons, 34% against 21%, said they had received more than one visit in the last month.
- 6.5 The visits hall was bright and spacious, and visitors could make purchases from a snack bar. There was also a children's play area, although PACT did not always have staff available to supervise this. Visitors told us that the online booking system was simple to use and that they had been treated with respect by staff at the prison.



### Visits hall

- 6.6 All wings benefited from in-cell telephones, which helped prisoners maintain family contact. Due to technical issues, the prison had been unable to offer prisoners secure video calls (see Glossary) for some months. This had been resolved and use had been slowly increasing, although, due to low staffing, video calling was not available at weekends.

## Reducing risk, rehabilitation and progression

Expected outcomes: Planning for a prisoner's release starts on their arrival at the prison. Each prisoner has an allocated case manager and a custody plan designed to address their specific needs, manage risk of harm and reduce the risk of reoffending.

- 6.7 Most prisoners did not spend long at Bullingdon. At the time of the inspection, over three-quarters had been there for less than six months and prison data indicated that most of the population changed every three months.
- 6.8 Leaders had only used limited data to identify the needs of the population for education, employment and offending behaviour programmes. The work of the teams involved in rehabilitation and resettlement was not sufficiently well coordinated and there were weaknesses in communication between them. This meant that prisoners were not always aware of the work done to support them, and in some instances they were given conflicting and incorrect information.

- 6.9 The effectiveness of the offender management unit (OMU) was undermined by staff vacancies. Only one of two senior probation officers (SPOs) was in post, there were vacancies for prison offender managers (POMs), and of the five probation POMs, only one and a half posts were filled. Vacancies among the prison officer POMs were exacerbated by regular cross-deployment of the small number of operational staff to other prison work. Not all prison POMs had completed job-specific training, although this was somewhat mitigated by the supervision provided by the SPO every six to eight weeks during which cases were discussed.
- 6.10 POMs sent an introductory letter to prisoners with whom they were allocated to work, and some followed this up with a face-to-face visit, but for many prisoners the contact after the initial introduction was poor. In some cases, we found no evidence of contact for many months. This was frustrating for prisoners and we heard many complaints about a lack of contact and responsiveness from the OMU. The prison had introduced OMU surgeries on the wings so that prisoners could speak with a POM, but the initiative had been unsuccessful due to a lack of staff and prisoners not being unlocked to attend. The lack of contact could have been offset by regular key work (see Glossary), but this had all but stopped (see paragraph 4.5); in October 2022, staff recorded 253 sessions, against a target of over 4,100. In the cases that we reviewed, the key work was not focused on supporting the work of the OMU or resettlement team.
- 6.11 All prisoners arriving at Bullingdon following sentencing at court were eligible for an initial offender assessment (OASys) containing a plan for how to progress through their sentence. At our previous inspection, over half of sentenced prisoners did not have an up-to-date OASys. Since then, the prison had, with the assistance of external HMPPS resources, ensured that nearly all eligible prisoners now had a current assessment. However, there was no clearly defined plan for how to meet the demand of completing these assessments following the withdrawal of the additional national resource.
- 6.12 In our survey, only 14% of prisoners said they had a sentence plan. Most of the plans we reviewed were of reasonably good quality. Although most included targets for the prisoner to engage with offending behaviour work, few had met these (see paragraph 6.18). Targets in education, training and employment were poorly achieved, with few prisoners able to demonstrate long periods of at least part-time work. However, more prisoners had been able to show progress against targets for engagement with mental health, and drug and alcohol services, as well as those for custodial behaviour.
- 6.13 In most of the cases we reviewed, the OASys also included a risk management plan; these were generally of reasonable quality. In cases that were nearing release, we saw evidence of communication between the POM and community offender manager (COM) about managing risk on release. This was often not recorded on NOMIS (the prison IT system), and could only be found through the IT system used by probation staff in the community.

## **Public protection**

- 6.14 Although risk had been managed reasonably well in the cases we checked, the prison did not have an effective process to make sure that this was done for all high-risk prisoners. Records of the monthly inter-departmental risk management meeting (IRMT) indicated that in the previous four months the only attendees had been the SPO and the public protection POM. The meeting only listed prisoners who were to be managed at levels 2 and 3 under multi-agency public protection arrangements (MAPPA) on release, and prisoners were only listed in the month before their release. POMs supplied written updates for some of the prisoners on the list, as did other departments, including security, safer custody and programmes. However, there was no evidence that these updates were discussed or acted upon.
- 6.15 The IRMT was not used to confirm that MAPPA levels had been set by the COM six months before release, and nor did the prison have any other system to confirm levels or ensure updates. Some of the reports prepared by POMs to update partners were descriptive rather than analytical, and too brief.
- 6.16 OMU case administrators screened new arrivals and highlighted potential public protection risks for consideration of phone and mail monitoring. In many cases it took two weeks before the decision to monitor was made, which was too long. There were only nine prisoners subject to mail and phone monitoring. This was unusually low for a reception prison with many prisoners arriving straight from the court with little known about their risks, and at the time of the inspection more than 100 prisoners were subject to a restraining order. Too few staff were identified to carry out monitoring, and on some days none were detailed to the role. Prisoners identified for monitoring were limited to making four 10-minute calls a day, which was punitive as prisoners not being monitored had no limit on the calls they could make. This restrictive measure was in place because of staff shortages, but given that there were only nine prisoners identified for monitoring it was hard to justify.

## **Categorisation and transfers**

- 6.17 POMs carried out initial categorisation decisions and subsequent reviews. Almost all decisions were completed on time and, in the cases we reviewed, POMs had recorded an appropriate range of evidence considered to support the decision. However, prisoners were not routinely offered the opportunity to participate in the review, and were not always informed of the decision and the reasons why it was made. This led to some prisoners feeling that the decisions had not been made fairly.

## Interventions

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

- 6.18 There was a good range of offending behaviour programmes, including provision for prisoners convicted of sexual offences, but vacancies in the programme team meant few prisoners had completed one since April 2022. The team was now fully staffed and planned to increase delivery in the next year to tackle waiting lists. However, POMs had referred too few prisoners to the programmes team to assess their need for work to address their offending behaviour.
- 6.19 Some prisoners had been provided with in-cell workbooks by their POM, but some POMs were not aware of the materials available and we found very few examples where workbooks had been used in a structured way with feedback sessions. The completion of workbooks was not used as evidence of prisoners' progress, for example at categorisation reviews. A few prisoners had benefited from bespoke one-to-one work from the regional psychology team. The chaplaincy had not yet resumed delivery of the Sycamore Tree victim awareness course.
- 6.20 There was some finance, benefit and debt support available for prisoners. The education department delivered the 'Get set for success' course, which included some elements of money management. Staff from the Department for Work and Pensions (DWP) attended the prison to give advice. Prison staff also helped prisoners to open bank accounts, but this took about three months, so some short-sentenced prisoners missed out.
- 6.21 The prison had recently appointed an employment lead who had developed some promising links with employers in the community. However, too few prisoners were able to sustain work while at the prison and data indicated that only 19% were released to employment, education or training. The prison was part of the Restart project, a Thames Valley initiative funded by the local criminal justice board and the Ministry of Justice, which gave prisoners the opportunity to work with a mentor offering support with employment and accommodation six months before release through to six months after. There was very little employment support for remand prisoners; until the time of the inspection, they were not offered careers information, advice and guidance at the prison.
- 6.22 Housing support was limited. The commissioned service provider attended the prison one day a week to agree accommodation action plans with prisoners nearing release. The prison was attempting to improve the data it collected on accommodation outcomes for prisoners. Even the incomplete data held by the prison suggested over 100 prisoners were released homeless in the previous six months.

## 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.

- 6.23 The resettlement team sent a questionnaire to all new arrivals, including those on remand, to identify areas they might need support with on release. When remand prisoners requested help with housing, the team could offer advice, such as how to protect a housing tenancy, but were unable to make referrals for accommodation support.
- 6.24 About 170 prisoners were released into the community each month. In our survey, only 40% of those who expected to be released within the next three months said someone was helping them to prepare for this.
- 6.25 The resettlement team met all prisoners assessed as low or medium risk (just over a third of sentenced prisoners) 12 weeks before their release date to review their resettlement needs and agree a release plan. Almost all the medium-risk prisoners we checked had a release plan, and appropriate referrals had been made to deliver this.
- 6.26 In many cases, prisoners' needs, especially for housing, were not addressed until just before release, and prisoners' anxieties were exacerbated due to a lack of contact to keep them informed of what was being done. After the 12-week check, the resettlement team did not routinely contact prisoners to update them. This was compounded by poor communication between the resettlement team and the OMU. Some POMs told us they were not clear what the resettlement team did, and the employment lead carried out an assessment of resettlement needs without any dialogue with the resettlement team (see paragraph 6.8).
- 6.27 In the previous 12 months, 155 prisoners had been released early on home detention curfew (HDC). The prison started preparing for this in good time, but over a third of all prisoners were still released after their eligibility date, mainly due to problems in the community, such as a lack of suitable bail accommodation. The resettlement team was not routinely contacted by the OMU when prisoners were to be released on HDC and so were unable to offer support.
- 6.28 There was limited practical support for prisoners on the day of release. Prisoners were offered a plain holdall to carry their belongings and there was a supply of clothing for those who needed it.

## 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. **Staff shortages were debilitating and had a major impact on outcomes for prisoners.**
2. **Prisoners spent too much time locked in their cells with little to do.**
3. **Leaders and managers had not designed an appropriate education curriculum that met the needs of the prison population, especially vulnerable and non-sentenced prisoners.**
4. **Leaders and managers did not identify the education, vocational training and commercial work starting points of individual prisoners.** Prisoners did not engage in meaningful education and workplace activities, which had a detrimental impact on their attitudes to learning and attendance at their lessons and therefore their ability to progress.
5. **Leaders and managers had not ensured that all prison and education staff knew how they could support prisoners to become more interested in reading and develop their reading skills.**

### Key concerns

6. **Leaders and staff had low expectations about what prisoners could be trusted to do or achieve, and didn't do enough to motivate prisoner engagement in purposeful activity.**
7. **The use of force was not always proportionate, and some staff did not do enough to de-escalate incidents before using force.**
8. **ACCT case management for prisoners at risk of harm did not always evidence targets and interventions that were tailored to their individual circumstances.**
9. **Living conditions on the main A–D accommodation were poor.**
10. **Prisoners had too little contact with their prison offender managers (POMs) and there were too few opportunities for prisoners to progress during their sentence.**
11. **Public protection arrangements were not robust enough to assure leaders that risk was managed properly.**

**12. Outcomes for remand prisoners were worse than convicted prisoners in key areas, including education, careers guidance and support for resettlement.**

## 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, early days support for most prisoners was reasonably good. Levels of violence had increased sharply but were lower than at similar prisons and there was now a downward trend. Too many adjudications were dismissed or not proceeded with. Levels of use of force had increased considerably and we were not confident that it was always justified. Segregation was reasonably well managed. Security processes were generally proportionate and the prison was well controlled. A wide range of actions had been taken to reduce drug supply, and availability was reducing. Levels of self-harm were lower than at similar prisons but there had been five self-inflicted deaths since the previous inspection and not all the work done to prevent suicide and self-harm was effective. Outcomes for prisoners were reasonably good against this healthy prison test.

#### Key recommendations

The prison should further reduce levels of violence, using a coordinated plan which is underpinned by regular analysis of the causes and which monitors the effectiveness of any actions taken. (S54)

**Achieved**

The prison should further reduce the demand for, and supply of, drugs using a coordinated plan which is underpinned by regular analysis and which monitors the effectiveness of any actions taken. (S55)

**Achieved**

Newly arrived prisoners should have their risk factors correctly identified and recorded when their risk of suicide and self-harm is being determined, and appropriate support should be put in place. (S56)

**Achieved**

## **Recommendations**

Prisoners should have good access to relevant support and information provided by peer workers and mentors. (1.11)

### **Partially achieved**

All prisoners should start their induction on the first working day after arrival. (1.12)

### **Achieved**

All victims of violence, self-isolators and young adults vulnerable to exploitation should be systematically identified and supported. (1.22)

### **Achieved**

The incentives and earned privileges scheme should offer enough incentives to encourage good behaviour, and be consistently applied. (1.23)

### **Not achieved**

A broad range of adjudication data should be routinely analysed, to identify trends and drive improvement. (1.29)

### **Achieved**

Prisoners should only be subject to full control and restraint as a last resort, with staff applying de-escalation techniques wherever possible. (1.34)

### **Not achieved**

Incidents of self-harm should be investigated to identify underlying causes, and data should be analysed to identify patterns and trends to inform action to reduce self-harm. (1.51)

### **Achieved**

Case management and constant supervision processes should effectively support prisoners at risk of suicide and self-harm. (1.52)

### **Achieved**

## **Respect**

### **Prisoners are treated with respect for their human dignity.**

At the last inspection, in 2019, staffing levels had increased substantially. Most staff were relatively inexperienced but relationships were reasonable. The condition and cleanliness of most cells were good but too many prisoners lived in cramped conditions. Access to clean clothing and other basic essentials was good. Prison shop arrangements were problematic. Applications were poorly managed and the number of complaints submitted was high. Prisoner consultation arrangements were developing. Equality work had been neglected and lacked effective senior leadership. Faith provision was adequate. Health services had improved and were

reasonably good overall. Outcomes for prisoners were reasonably good against this healthy prison test.

### **Key recommendations**

Prisoners should not be held in overcrowded conditions. (S57)

**Not achieved**

Equality and diversity should be given sufficient priority, the needs and outcomes for protected groups should be monitored and effective remedial action taken when inequality is identified. (S58)

**Achieved**

### **Recommendations**

Staff should ensure appropriate supervision of prisoners, especially at critical times such as the serving of food and medicine administration, to prevent bullying and diversion. (2.5)

**Not achieved**

Communal shower and toilet areas should be clean, well maintained and adequately ventilated. (2.14)

**Not achieved**

Prisoners should be able to submit applications confidentially and receive a timely and accurate response. (2.26)

**Not achieved**

Legal services should be available, especially for those on remand. (2.27, repeated recommendation 2.37)

**Not achieved**

Health promotion material should be available throughout the prison, in a variety of languages and formats, to meet the needs of the prison population. (2.59)

**Partially achieved**

A comprehensive primary mental health service should be provided, offering a full range of support for prisoners with mild and moderate mental health problems. (2.78)

**Achieved**

The substance use psychosocial therapy needs of prisoners should be met in a timely manner. (2.87)

**Achieved**

Patients risk-assessed as not being able to have their medicines in-possession should not be given their medicines in this way. (2.95)

**Achieved**

## Purposeful activity

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

At the last inspection, in 2019, prisoners received a predictable regime, which mostly ran to time. Too many prisoners were locked up during the working day. Library and PE arrangements were reasonable. There had been positive developments in education, skills and work but provision required further improvement. There were too few activity places for the prison population, and attendance in education classes was too low. The quality of teaching and learning required improvement overall. In most education classes, prisoners made good progress and achievements were generally good. However, most prisoners were employed in industry and prison work, where they were not able to gain recognition of skills or vocational qualifications. Outcomes for prisoners were not sufficiently good against this healthy prison test.

### Key recommendations

Leaders and managers should increase the number of activity places available, to enable all eligible prisoners to attend purposeful activity. The prison induction should include help for prisoners to choose the activities best suited to their career aspirations. Instructors in prison work and industry should record the development of prisoners' employability skills, and offer opportunities to achieve accredited qualifications wherever possible. (S59)

#### Not achieved

Managers should continue to improve attendance rates in education, and increase the proportion of functional skills learners who complete and pass their awards. Staff in prison work and industries should provide better outcomes for prisoners by ensuring that they recognise and record prisoners' development of employability skills, and provide access to vocational qualifications wherever possible. (S60)

#### Not achieved

Managers should ensure that quality monitoring in all education and work areas clearly identifies weaknesses in teaching and is followed up by targeted staff development to address them. Access to information technology to support learning should be improved. Managers should monitor the quality of assessment and feedback to learners, to ensure that it is timely and accurate. In prison work and workshops, staff should be supported to enable them to embed mathematics and English learning in prisoners' routine work. (S61)

#### Partially achieved

## **Recommendation**

Information about prisoners' mathematics and English skills should be passed efficiently to teachers and instructors, so that they can provide appropriate support in these areas. (3.19)

**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, prisoners were supported well to maintain contact with their families. Work to reduce reoffending was critically undermined by weaknesses in offender management. Levels of offender supervisor contact were poor. Arrangements to supervise high-risk prisoners were inadequate. Half of eligible prisoners did not have an assessment of their risk and needs, or a sentence plan, which seriously impeded their progression and access to interventions. Too many prisoners were released beyond their home detention curfew eligibility date. Public protection arrangements were poor and potentially placed victims at risk. The community rehabilitation company provided good release planning for the large numbers of prisoners being released. Despite strenuous efforts, at least a third of prisoners were released without sustainable accommodation. There was reasonably good help for prisoners to manage their finances. Outcomes for prisoners were not sufficiently good against this healthy prison test.

### **Key recommendations**

All eligible prisoners should have an up-to-date offender assessment system (OASys) assessment to inform their progression and access to interventions. (S62)

**Achieved**

All eligible prisoners should have regular contact with an appropriately trained offender supervisor, to drive sentence progression. (S63)

**Not achieved**

The interdepartmental risk management team meeting should review all high-risk prisoners due for release in sufficient time to address any gaps in risk management planning. (S64)

**Not achieved**

Contact restrictions should be consistently applied to all prisoners who are assessed as a continuing risk to children, and any changes in contact carefully evidenced. (S65)

**Achieved**

The number of prisoners whose home detention curfew is delayed owing to a lack of suitable accommodation, and the number being released from Bullingdon either homeless or into temporary accommodation should be reduced. (S66)

**Not achieved**

### **Recommendations**

Offence-related mail and telephone monitoring for new arrivals who require it should start promptly, to prevent any unmonitored victim contact. (4.20)

**Not achieved**

Decisions to recategorise prisoners to category D should be informed by an up-to-date offender assessment system (OASys) assessment. (4.24)

**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 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
Deborah Butler	Team leader
Martyn Griffiths	Inspector
Lindsay Jones	Inspector
Martin Kettle	Inspector
Rebecca Mavin	Inspector
David Owens	Inspector
Nadia Syed	Inspector
Rachel Duncan	Researcher
Alexander Scragg	Researcher
Joe Simmonds	Researcher
Reanna Walton	Researcher
Steve Eley	Lead health and social care inspector
Maureen Johnson	Health and social care inspector
Si Hussain	Care Quality Commission inspector
Mathew Tedstone	Care Quality Commission inspector
Andrew Holland	Ofsted inspector
Bev Ramsell	Ofsted inspector
Sambit Sen	Ofsted inspector
Marin Ward	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.

### **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).

### **Reconnect**

An NHS England programme being piloted across several prisons to provide wraparound release support for at-risk prisoners aimed at engagement with community health and support services.

### **Secure video calls**

A system commissioned by HM Prison and Probation Service (HMPPS) that requires users to download an app to their phone or computer. Before a visit can be booked, users must upload valid ID.

### **Social care package**

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

### **Time out of cell**

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

## **Appendix III Further resources**

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

### **Prison population profile**

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

### **Prisoner survey methodology and results**

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

### **Prison staff survey**

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

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