Report on an unannounced inspection of

HMP Long Lartin

by HM Chief Inspector of Prisons

5–16 December 2022

Contents

Introduction

Located in the Vale of Evesham, Worcestershire, Long Lartin is a high security prison holding up to 514 adult men, many of whom are among the highest risk and most serious offenders in the country. At the time of our inspection, for example, of the 478 prisoners in residence, 141 were designated as category A, the highest security classification, and 449 were serving indeterminate sentences including life. Walking around the prison wings, we met many individuals who faced or had already spent many years, even decades, in the prison, with the imposition and requirements of security an ever-present pressure on their experience. Many expressed to us their frustrations with life in Long Lartin, and some their sense of hopelessness.

Overall, this inspection was disappointing, with assessments in three of our four healthy prison tests – safety, purposeful activity, and rehabilitation and release planning – all deteriorating since we last inspected in 2018. Only in respect did outcomes remain the same, although it was still judged not sufficiently good. For a high security prison, most surprising among these tests was safety, where the priorities and purpose of such institutions ordinarily mean better scores. While there were some positive aspects, arrangements for the reception, assessment and induction of new arrivals were limited, the rate of assaults against staff was the highest among comparable prisons, and other metrics such as adjudications, use of force and, until the week before our inspection, the number of prisoners segregated, were all high. Security processes, as we would expect, were generally good, although the mandatory drug testing rate was a surprisingly high 20%. The rate of self-harm had doubled, making it the highest among comparable prisons, with 92 separate individuals having self-harmed over the past year. There had been eight self-inflicted deaths since the last inspection.

First opened in the early 1970s, the prison had undergone at least two significant phases of development since the late 1990s, leaving it with a mix of accommodation types. Environmental standards varied across the site: some accommodation units were not clean enough, investment in the older units was needed, and there was a problem with rat infestation in the grounds. Reasonable staff-prisoner relationships were something of a mitigation, with most prisoners saying they were treated with respect, and we saw some developing structures in place to support prisoner consultation. That said, many prisoners felt frustrated at their inability to get things done, formal complaints were high and arrangements which might have supported and made better use of reasonable relationships, such as key work, were lacking. Work to promote equality was similarly inconsistent. Outcomes in health care were generally good.

A split daily regime meant that most prisoners could be unlocked for at least 2.5 hours a day and twice that for the few who had a job. Limited evening association up to 6.30pm was available for some prisoners, although a repeated complaint among those we spoke to was the unpredictability of routines. Severe officer shortages were directly linked to the very limited opportunities to engage in purposeful activity. Our colleagues in Ofsted judged the overall effectiveness of learning and skills provision as ‘inadequate’, their lowest assessment. Added

to this we found a series of significant shortcomings in the promotion of family ties, offender management, offending behaviour interventions and public protection arrangements, all issues that should have been institutional priorities.

This inspection gave us the sense that Long Lartin needed a reset. Leaders were not fully sighted on several of the weaknesses we identified and tended to overestimate their achievements. Staffing shortages were hindering delivery, and while there were some useful plans to improve this situation, implementation was slow. Above all, the prison needed a clear focus on how to meet the needs of the very particular type of prisoner it held. We have identified several priorities which we hope will assist this process.

Charlie Taylor
HM Chief Inspector of Prisons
February 2023

What needs to improve at HMP Long Lartin

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

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

Priority concerns

1. **The level of self-harm had doubled since our last inspection and was the highest among comparable prisons, but there was no plan to reduce it.**

2. **Levels of violence were too high, especially against staff.** The safety team was under-resourced, and work to address the causes of violence remained limited.

3. **The prison's infrastructure was in very poor condition and in need of investment**. Many cells had no toilet or running water, and the heating, roofs, showers, kitchen equipment and some physical security systems were failing.

4. **Prisoners spent too much time locked up and the regime was delivered inconsistently.**

5. **Provision of education, training and work was insufficient, and prisoners were not allocated to courses that met their needs.**

6. **Prisoners had insufficient contact with offender managers to support risk reduction and sentence progression.**

Key concerns

7. **There was a high level of illicit drug use, but plans to reduce drug supply or to limit demand were lacking.**

8. **Too few key work sessions were being delivered, limiting staff-prisoner relationships and sentence progression.**

9. **The prison did not do enough to address perceived disproportionate treatment among those from ethnic and religious minorities or to cater for the prison's large number of disabled prisoners**.

10. **The health care inpatient unit and the end-of-life cell were not suitable and too many prisoners were placed in the unit inappropriately.**

11. **The shortage of pharmacy staff was affecting service delivery.** Prescribing was not subject to effective oversight or scrutiny, and governance of out-of-hours' medicines use was poor.

12. **There was not enough mathematics or English provision, and teaching standards in those subjects were poor.**

13. **Leaders had made insufficient progress in improving prisoners' reading levels.**

14. **Leaders had not developed a personal development curriculum across education and work.** Prisoners were not given formal opportunities to learn about equality, diversity or recent significant changes in society.

15. **There were shortfalls in public protection arrangements.** The interdepartmental risk management meeting was poorly attended and there was a lack of information sharing. Ongoing action relating to risks to children remained unresolved.

About HMP Long Lartin

Task of the prison
Long Lartin is a high-security prison for category A and B male prisoners. It holds mostly those with a determinate sentence of over 10 years, as well as lifers and prisoners with an indeterminate sentence for public protection.

Certified normal accommodation and operational capacity (see Glossary)
Prisoners held at the time of inspection: 478
Baseline certified normal capacity: 613
In-use certified normal capacity: 533
Operational capacity: 514

Population of the prison
- An average of 136 new prisoners received each year (about 12 per month).
- 141 category A prisoners, including 8 high-risk category A prisoners.
- 449 life sentence prisoners, including 20 prisoners serving and indeterminate sentence for public protection (ISPP).
- 59 foreign national prisoners.
- 38% of prisoners from black and minority ethnic backgrounds.
- An average of three prisoners released into the community each year.
- 15% of prisoners in specialist units.

Prison status and key providers
Public

Physical health provider: Practice Plus Group
Mental health and substance misuse treatment provider: Inclusion (part of the Midlands Partnership NHS Foundation Trust)
Prison education framework provider: Milton Keynes College
Escort contractor: GEOAmey

Prison department
Long-term high-security estate

Brief history
Long Lartin was built in the 1960s as a war department ordnance depot and opened as a category C prison in 1971. The infrastructure was upgraded to meet high-security conditions in 1973. Further improvements in security were made between 1995 and 1997 and an additional wing, Perrie, was opened in June 1999. In 2009, a new purpose-built unit, Atherton (E and F wings), replaced older wings, increasing the capacity of the prison.

Short description of residential units
A – capacity for 77 prisoners in cells without in-cell sanitation but closed for a night sanitation upgrade.
B – capacity for 77 vulnerable prisoners in cells without in-cell sanitation.
C – capacity for 76 vulnerable prisoners in cells without in-cell sanitation.
D – capacity for 77 prisoners in cells without in-cell sanitation.
E – modern open plan unit for 95 prisoners.

F – modern open plan unit for 89 prisoners.
P – Perrie Blue – an incentivised substance-free living unit for 42, currently holding 26 prisoners.
Q – Perrie Red – a modern unit for 75, currently holding 61 prisoners.
Health care inpatient unit – for seven prisoners, including one cell that can provide end-of-life care.
Pre-psychologically informed planned environment unit – capacity for 18 prisoners.

Name of governor and date in post
Steve Cross, July 2019

Changes of governor since the last inspection
Jamie Bennett, January 2019–June 2019
Clare Pearson, November 2016–December 2018

Prison group director
Will Styles

Independent Monitoring Board chair
Sue Harrop

Date of last inspection
15–16 and 22–26 January 2018

Section 1 Summary of key findings

1.1 We last inspected HMP Long Lartin in 2018 and made 49 recommendations, three of which were about areas of key concern. The prison fully accepted 28 of the recommendations and partially (or subject to resources) accepted 13. It rejected eight of the recommendations.

1.2 In February 2021, during the COVID-19 pandemic, we conducted a scrutiny visit at the prison. We made eight recommendations about areas of key concern.

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

Progress on key concerns and recommendations from the full inspection

1.4 Our last inspection of HMP Long Lartin 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 follow up on recommendations about areas of key concern to help leaders to continue to drive improvement.

1.5 At our last full inspection, we made three recommendations about key concerns. At this inspection we found that the recommendation under rehabilitation and release planning had been partially achieved. However, both recommendations under respect and purposeful activity had not been achieved. For a full summary of the recommendations achieved, partially achieved and not achieved, please see Section 8.

Progress on recommendations from the scrutiny visit

1.6 During the pandemic we made a scrutiny visit to HMP Long Lartin. Scrutiny visits (SVs) focused on individual establishments and how they were recovering from the challenges of the COVID-19 pandemic. They were shorter than full inspections and looked at key areas based on our existing human rights-based *Expectations*. For more information on SVs, visit https://www.justiceinspectorates.gov.uk/hmiprisons/about-hmi-prisons/covid-19/scrutiny-visits/.

1.7 At the SV we made some recommendations about areas of key concern. As part of this inspection, we have followed up those recommendations to help assess the continued necessity and proportionality of measures taken in response to COVID-19, how well the prison is returning to a constructive rehabilitative regime, and to provide transparency about the prison's recovery from COVID-19.

1.8 We made eight recommendations about areas of key concern. At this inspection we found that three of the recommendations had been achieved, one had been partially achieved and four had not been achieved.

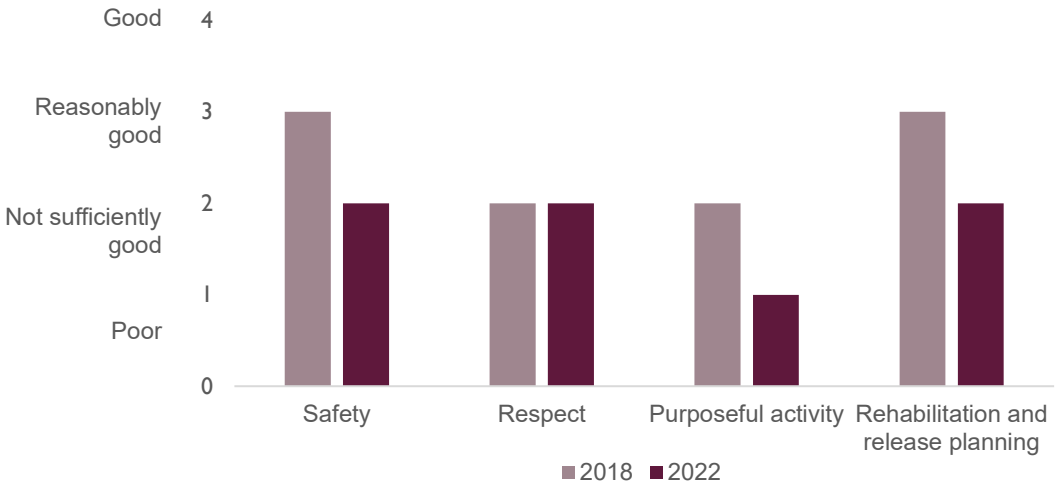
Outcomes for prisoners

1.9 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).

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

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

Figure 1: HMP Long Lartin healthy prison outcomes 2018 and 2022



Safety

At the last inspection of Long Lartin in 2018 we found that outcomes for prisoners were reasonably good against this healthy prison test.

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

1.12 Reception was unwelcoming, and interactions with prisoners were limited. Not all prisoners had a recorded initial safety interview to explore any potential vulnerabilities, and induction was minimal.

1.13 The number of staff assaults was the highest compared with similar prisons and had risen in the previous year. There had been several

serious incidents, which had been managed well. Leaders analysed data to identify learning concerning violence and had taken some steps to respond, but staff shortages in the safety team meant that work to address the causes of violence remained limited.

1.14 Not all challenge, support and intervention plan (see Glossary) investigations were well documented, and interventions were not consistently targeted at prisoners' needs. The weekly safety intervention meeting was well attended and there was evidence of multidisciplinary care planning for the most complex prisoners. The incentives policy was of limited impact in promoting prisoners' behaviour and engagement.

1.15 The number of adjudications had increased since our last inspection, but many were for low-level behavioural issues that could perhaps have been addressed more effectively by other means.

1.16 The number of incidents involving force was high and had increased considerably since the last inspection. Too much documentation was incomplete, and incidents received insufficient scrutiny. Special accommodation had been used just twice during the previous year, compared with 20 times in the six months before the last inspection.

1.17 The number of prisoners being segregated was high and the large segregation unit had often run at or near capacity, with others being segregated on wings. A recent decision to reduce the capacity of the unit to 26 was welcome. The length of stay for many prisoners was very long, and the regime remained very limited. Unit staff managed some challenging behaviour well. However, only two meetings to monitor segregation had been held during 2022. A stakeholder panel to provide oversight had recently been established.

1.18 Security processes were thorough – there was an excellent flow of intelligence, and it was analysed and acted on promptly. Cooperation between prison staff and the police was very good, and there was a rigorous and constructive approach to counterterrorism and anti-corruption work. Drugs were a problem, with the mandatory drug testing positive rate approaching 20%. Planning to reduce drug supply or to limit demand was lacking.

1.19 There had been eight self-inflicted deaths and two deaths from non-natural causes since our last inspection. Prisons and Probation Ombudsman recommendations had mostly been addressed. The recorded rate of self-harm had doubled since our last inspection. While a small number of prisoners accounted for a substantial proportion of incidents, 92 had self-harmed in the previous year, the highest rate compared with similar prisons. A range of data was reviewed, but they had not been used to underpin a strategic plan to reduce self-harm.

1.20 The standard of assessment, care in custody and teamwork case management documentation for prisoners at risk of suicide or self-harm was variable, but we found good examples of multidisciplinary work to support the individual care of some prisoners with complex needs.

There had been some useful efforts to bring in families to support vulnerable men.

Respect

At the last inspection of Long Lartin in 2018 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.

1.21 In our survey, 71% of prisoners said staff treated them with respect, but only 34% said a member of staff had checked on them in the previous week. Most interactions we observed were perfunctory and transactional. During association, we saw staff supervising from a distance, rather than interacting with prisoners. Key work sessions (see Glossary) did not take place frequently enough.

1.22 Living conditions on the older wings remained inadequate, and we found most communal areas poorly maintained and dirty. There were some serious heating and hot water failures during the inspection. The remote electronic unlocking system (Night-San) that allowed access to sanitation on the older wings had been upgraded and worked more efficiently, but it remained unacceptable that prisoners did not have free access to a toilet or running water.

1.23 Only 24% of prisoners in our survey said the food was good, but this was partly mitigated by the self-catering facilities, which prisoners appreciated. Nevertheless, there was a lot of broken equipment in catering facilities and supervision was limited.

1.24 Consultation meetings were well attended by managers, but they did not relieve prisoners' sense of frustration that recurring problems were not being resolved. Applications were still not tracked and there was no oversight of responses. The number of complaints was high, and responses were variable in quality, although most complaints were now answered promptly.

1.25 Quarterly equality meetings were well attended, but the prison had been slow to implement action. The number of discrimination incident reporting forms submitted in the previous year was high. Investigations were generally adequate, and replies were appropriate in most cases.

1.26 There was no consultation with prisoners with protected characteristics and the prison did not have a clear understanding of their needs. A large number of prisoners had disabilities, but similarly their needs were not always met. In our survey, disabled prisoners reported feeling less safe.

1.27 The active chaplaincy gave all main faith groups the opportunity to take part in religious services every week, but study groups remained

suspended. The restricted regime meant that some Muslim prisoners did not have adequate time to wash before Friday prayers.

1.28 The clinical and strategic leadership of health services was effective. Primary care waiting lists were well managed and waiting times were minimal. Long-term conditions were managed well. The inpatient unit and end of life cell were not suitable. We found instances of the unit being used as an overspill for the segregation unit, which was inappropriate.

1.29 Arrangements for identifying prisoners' social care needs and providing them with personal care were in place, but there was a shortage of cells catering for prisoners with a disability. Prisoner carer support arrangements lacked supervision, presenting potential safeguarding risks.

1.30 Prisoners generally had good access to support for mental health and substance misuse problems, but too many appointments were cancelled due to regime issues. Patients requiring a transfer to specialist mental health services under the Mental Health Act continued to wait too long for a bed.

1.31 Medicines management arrangements were effective, but there were some weaknesses in governance processes. Dental provision was very good – a well-established dental team provided prisoners with timely access to treatment.

Purposeful activity

At the last inspection of Long Lartin in 2018 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.

1.32 A split regime was operating, which meant most prisoners were locked up either in the morning or afternoon. Many who were not working had just two and a half hours out of their cells plus the time it took to collect their meals. Those who had a job could spend five hours unlocked. Some evening association was provided when possible, but prisoners complained about being unlocked for very short periods and the unpredictability of the regime.

1.33 The library could have provided a good service, but very few sessions took place because of a lack of staff to escort prisoners. Access to the gym was much better, although accredited training was not yet available.

1.34 Severe staff shortages meant senior leaders did not provide prisoners with sufficient activities in education, training or work to meet their needs. Very few workshops were open, and too many prisoners were involved in low-level jobs or wing work that was repetitive and did not

challenge them. Vulnerable prisoners' access to education and work was too restricted.

1.35 Prisoners in English and mathematics classes did not receive effective teaching and made slow progress. There were insufficient classes to meet need and about one third of the population were not strong readers. Leaders did not yet have an implementation plan to match the ambition of the published reading strategy.

1.36 There was no specialist information, advice and guidance adviser and, as a result, prisoners' needs were not always identified at induction. A common personal development curriculum had not yet been developed across education or work, and prisoners were not given formal opportunities to learn about equality, diversity or recent significant changes in society.

Rehabilitation and release planning

At the last inspection of Long Lartin in 2018 we found that outcomes for prisoners were reasonably good against this healthy prison test.

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

1.37 There was sufficient capacity for visits, but there were delays in start times. The video-calling service only provided half-hour slots per session, and was further limited by connection issues and regime curtailments. The Prison Advice and Care Trust (PACT) provided some excellent support for prisoners' families. However, the poor regime restricted prisoners' access to phones.

1.38 Nearly three-quarters of prisoners were serving life or indeterminate sentences for public protection and about one-third were category A status. The prison did not have an up-to-date reducing reoffending strategy, action plan or needs analysis, and meetings did not discuss all relevant pathways.

1.39 There were ongoing gaps in the oversight and management of the offender management unit, and staffing shortfalls had resulted in low morale, high workloads and staff working outside their remit. Not enough was being done to make sure joint working across the prison was effective.

1.40 The level of contact prison offender managers had with prisoners was poor and they were not all seen within a reasonable timeframe when they arrived at the prison. Too many prisoners were unaware of their sentence planning and were not involved in the process. There continued to be a backlog of offender assessment system reports, and the standard of documentation was mixed.

1.41 All new prisoners were screened on arrival and public protection monitoring arrangements were well managed, but the

interdepartmental risk management meeting was poorly attended and there was a lack of information sharing. Ongoing action relating to risks to children remained unresolved. Contributions to multi-agency public protection arrangement meetings were mainly good, but risk management plans varied.

1.42 Re-categorisation assessments were mainly well considered, but there was not always evidence of the prisoner being involved. Population pressures meant the prison had recently been directed not to move category C prisoners out of the establishment.

1.43 A range of offending behaviour programmes was offered, but it did not meet the needs of the whole population. There were no group interventions available to vulnerable prisoners. The number of prisoners completing interventions was very small, and although robust plans were in place to increase this number, group sessions were limited because of the restricted regime. The allocation of interventions was based on significant dates in a prisoners' sentence, further limiting their opportunities for re-categorisation and progression.

1.44 The pre-psychologically informed planned environment unit was well run. It had suitably trained and supervised staff, and clinical leadership was strong. Most prisoners were positive about the programme.

1.45 Only five prisoners had been released from the prison into the community in the last year, but all prisoners had been provided with appropriate accommodation, mainly to approved premises that were suited to their needs.

Notable positive practice

1.46 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.

1.47 Inspectors found no examples of notable positive practice during this inspection.

Section 2 Leadership

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

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

2.2 Leaders' self-assessment of their strengths and challenges was not always accurate and was over optimistic. It did not accurately identify, for example, weaknesses that we found during our inspection in rehabilitation and release planning or public protection arrangements. It had similarly overestimated achievements in other work, such as the promotion of equality. There were also no timebound targets or measures of success, and individual managers were not held to account effectively.

2.3 Leaders had provided staff with insufficient direction. Many custodial managers were new in post or had been temporarily promoted, and there was not enough focus on improvement. Key work (see Glossary) had largely stalled, which had undermined staff-prisoner relationships. Staff and prisoners complained to us about a lack of communication and consistency in the regime, despite the governor's regular broadcasts to prisoners on Way Out TV (the prison's TV channel).

2.4 A large shortfall in prison officers had severely impacted the daily regime and limited the amount of time prisoners spent unlocked or in purposeful activity. Prison officer vacancies had recently declined from 93 to 85, but attrition remained high. HM Prison and Probation Service (HMPPS) support to deploy detached duty officers and overtime bonus schemes were easing the situation.

2.5 Leaders had been slow to implement plans to better support new staff and improve recruitment and retention. A learning and capability manager and a new colleague mentor had been recruited, and a workshop was being repurposed to provide a staff support and careers centre. Targeted local recruitment campaigns were also planned.

2.6 Important outcomes in offender management were undermined by significant gaps in leadership. Throughout the inspection, prisoners expressed their feelings of hopelessness and growing frustration at the lack of opportunities for progression with their sentence. There were also insufficient education, skills and work activities, and Ofsted graded the provision as inadequate across all its assessments.

2.7 Efforts to improve safety had been hampered by a lack of staff in the safer custody team. Although leaders had collected some data and

taken action, they had not been drawn together in a cohesive plan to promote improvement.

2.8 Poor living conditions in the ageing accommodation were exacerbated by the failure of the facilities management provider to carry out repairs. The backlog of jobs was even higher than at our last inspection, despite leaders meeting regularly to track performance.

2.9 HMPPS investment was needed to improve the failing infrastructure, including the heating, roofs, old showers, kitchen equipment, the inpatient unit and outdated physical security systems. There were also no telephones in cells, although we were told that installation was imminent.

2.10 Investment in upgrading the sanitation system had improved its reliability, but almost half the population still had a bucket instead of a toilet and no running water to wash their hands in their cell. This indignity was compounded by the amount of time prisoners now spent locked up.

2.11 The leadership team needed to focus more on making sure basic amenities and the regime operated effectively, and on building staff confidence and the capabilities of new middle managers.

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 The reception environment was a small, unwelcoming area. Limited information was available, including tatty and outdated posters and booklets. Prisoners spent most of their time in reception standing at the main desk or locked in a holding cell, a small room with a bench.

Holding room in reception

3.2 Staff interactions with prisoners were limited to processes, signing compacts and searching. The designated search team (DST) searched all new arrivals, and 71% of prisoners in our survey said they were searched respectfully. The body scanner was used on an intelligence-led basis. After being searched, the DST processed prisoners' property. New arrivals also underwent a health care screening, which usually took place in reception. While reception was not busy, the process meant that prisoners spent about two hours there. There were no prisoner peer workers and little for new arrivals to do.

3.3 Arrangements to support prisoners on arrival had been reviewed recently but their application remained inconsistent. An initial safety interview usually took place on the wing, but this was not always recorded and sometimes failed explore any potential vulnerabilities before the prisoner was locked up on their first night.

3.4 Leaders had allocated specific cells for new arrivals. Vulnerable prisoners were housed on C wing and the general population on Perrie Red, although those who were high-risk category A prisoners could be allocated in any unit. While cells were clean, they were shabby. The induction cell on C wing did not have an in-cell toilet and staff said they were short of additional buckets or portable toilets during our visit, which was poor (see paragraph 4.8).

First night cell

3.5 In our survey, prisoners were significantly more negative than those in similar prisons about their first night. For example, only 40% of new arrivals compared to 59% elsewhere said they had received toiletries and basic items, and only 55% compared to 76% elsewhere said they were offered something to eat.

3.6 New arrivals received additional checks every two hours on their first night. Safer custody officers generally met new arrivals in their first couple of days and new arrivals were flagged at the weekly safety intervention meeting (SIM) (see paragraph 3.45).

3.7 The induction took place on an individual basis but was minimal. It involved a peer mentor going through a booklet. In our survey, fewer prisoners than at our last inspection said they had received an induction (76% compared with 95%). There was insufficient oversight to make sure prisoners received the full induction.

Managing behaviour

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

Encouraging positive behaviour

3.8 There had been 107 violent incidents in the year leading to the inspection, including 42 assaults on prisoners and 65 on staff. This was comparable to the last inspection. In our survey, 28% of prisoners said they felt unsafe, similar to comparable establishments. The level of prisoner-on-prisoner violence varied from month to month but was roughly equivalent to similar prisons. The rate of staff assaults was the highest among comparable prisons and had risen in the previous year. Many prisoners and staff told us that they felt that prisoners' growing frustrations with the restrictive regime was driving much of the violence in the prison, particularly assaults on staff.

3.9 The prison's population presented a high level of risk, and there had been several serious incidents in the previous year, which had been managed well. However, some of the incident reports we viewed in records produced by the prison described incidents involving injuries to prisoners and staff which required hospital treatment, which had not been recorded as being serious. Improved oversight of recording had led to an improvement in recent weeks, but we were not confident that the number of incidents that were serious in nature in the last year had all been accurately recorded.

3.10 The safer custody team was small and, until shortly before the inspection, officers had regularly been redeployed due to staffing shortages. These limitations in the team's capacity meant that they had been unable to conduct consistent, focused work to identify the causes of violence or take action to address them, and some of the action that had been taken was reactive. For example, staff had identified that drug use was often a factor in violent behaviour. As such, they had recently made the head of safer custody responsible for a new drug strategy aimed at addressing this. However, this work was in its early stages at the time of our inspection.

3.11 There had been 142 referrals for Challenge, support and intervention plans (CSIPs) in the previous year, 36 of which had progressed to plans. In the sample of plans we reviewed, the standard of investigations varied, and they were not always well documented. Interventions were not always targeted at individual prisoners' needs. In some cases, plans had not been reviewed or had been closed prematurely, potentially limiting their effectiveness.

3.12 There had been some promising work with prisoners to promote positive behaviour. The safer custody team had visited most of those

who had been involved in violence or who were displaying challenging patterns of behaviour to discuss any problems they were experiencing and offer support. There had also been some useful wing-based well-being clinics, offering support to improve prisoners' behaviour.

3.13 The weekly SIM was well attended and there was evidence of appropriate multidisciplinary care planning for the most complex prisoners. During our inspection, we also saw evidence of multidisciplinary meetings being set up to discuss individual prisoners who required additional support. This support led to positive progress in many cases, but there were several especially challenging prisoners who had made little progress in recent months despite regularly being discussed during the SIM.

3.14 The incentives policy was not used to full effect. There was not enough distinction between the standard and enhanced levels to promote positive behaviour. Although leaders had some plans to improve this, we were told that staffing levels prevented them from making changes which might better incentivise prisoners, and at the time of our inspection there was insufficient work being done to promote positive behaviour throughout the establishment. Some less experienced staff members did not feel confident applying the incentive scheme, and we found some instances of poor behaviour that should have been managed through the policy instead of being sent for adjudication.

Adjudications

3.15 The number of adjudications had been rising in the year leading to the inspection, in part because the prison's incentives policy was not always being used effectively (see paragraph 3.14). Paperwork we reviewed showed that the process was conducted fairly.

3.16 There had been no adjudication standardisation meetings in the previous year, although this was offset in part by the deputy governor conducting quality assurance.

3.17 There was a backlog of 224 adjudication cases which had been adjourned. Many had been delayed for long periods, and some serious charges had been written off because of delays in hearing adjudications, which potentially undermined the effectiveness of the process. The number of police referrals had decreased since the previous inspection and were now well managed.

Use of force

3.18 The increase in the recorded use of force we identified at the last inspection had continued and rates were now even higher, with 322 incidents reported in the 12 months to the inspection, compared with 210 last time. Over half of all incidents involved the use of physical restraint and documentation and videos we reviewed showed the almost routine use of handcuffs, without considering the risks the prisoner posed.

3.19 During the previous year, two incidents had led to batons being drawn and three had involved PAVA incapacitant spray being drawn and deployed twice. A basic reporting form had been completed for at least one of the PAVA incidents, but there was no routine enquiry into the use of batons or PAVA to make sure it was justified, highlighted any lessons to be learned or identified good practice.

3.20 Too many use of force dossiers remained incomplete – about a quarter were missing at least one contribution. It was poor that some of these dated back almost a year. Overall, incidents were not scrutinised sufficiently, and there was very limited evidence of any video recording of incidents being reviewed.

3.21 We reviewed five video recordings of incidents and saw evidence of some poor practice. We were not satisfied that de-escalation techniques were routinely considered. Regular and routine reviews would have identified these issues so remedial action could be taken.

3.22 A good range of data was collated, and the monthly use of force meeting considered any disproportionality, identified incident hotspots and action required to address any emerging issues.

3.23 The use of special accommodation was much lower than at our last inspection. In the previous 12 months, it had been used just twice compared with 20 times in the six months before our last inspection. Reports we reviewed indicated its initial use to have been proportionate, but ongoing recording failed to demonstrate the need for continued use and we considered that at least one prisoner could have been brought out of special accommodation sooner.

Segregation

3.24 We found the level of segregation high. In our survey, more prisoners said they had been segregated in the previous six months than at similar prisons (25% compared with 13%). The large segregation unit had been operating at or near capacity, which meant prisoners were segregated on wings when it was full. More than 40 prisoners could be segregated at any one time.

Large, two-storey segregation unit

3.25 However, in the week before our inspection, the capacity of the unit had been reduced to 26 and some cells were being decommissioned and turned into activity rooms or interview or casework rooms.

3.26 Not all those in the unit had come from residential units at Long Lartin – nine had been transferred from other segregation units within the long-term high-security estate (LTHSE). The average length of stay for those in the unit was high at about 150 days and was similar to what we have found at other LTHSE prisons.

3.27 Communal areas were mostly clean and well maintained. Cells were in reasonable condition with sufficient furniture and little evidence of graffiti, but some floors and too many toilets were in a poor state.

Segregation unit toilet

3.28 There were five showers, four on the upper landing and one on the lower landing. The lower landing shower offered little privacy and needed modernisation.

Segregation shower

3.29 The regime in the unit remained poor – it consisted of a daily phone call, shower and exercise alone in one of the five small exercise yards. Advanced plans were in place to provide some activity, including fitness training, peer mentor support sessions and recreation in the recently adapted former cells. We considered that the very recent move to allow some prisoners to collect their meals from the servery was positive.

3.30 Unit staff managed some very difficult men with great skill, and the staffing levels required for each prisoner were regularly reviewed to reflect risks, behaviour and compliance with the regime. The routine high-control handcuffing of some prisoners in the unit no longer took place and measures were now proportionate. Staff-prisoner relationships were good, but the positive interactions we observed were seldom recorded in electronic case notes.

3.31 All prisoners in the unit had reintegration plans, and regular reviews sought to motivate them to return to a normal location at the prison. The reviews and other interventions offered by staff, such as those from the prison's clinical psychological team, had a positive impact on many of the prisoners and some frequent violent behaviour was being addressed. Prisoners who had been transferred from other LTHSE segregation units were managed under the Pathways to Progression initiative (see Glossary), which supports long-term segregated

prisoners to progress out of segregated conditions through gradual reintegration.

3.32 Despite some dynamic leadership in the unit, wider managerial input had been limited to two monitoring meetings in the previous year. However, a stakeholder panel had recently been established to provide strategic oversight of operational management and of plans to improve the unit.

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.

3.33 Leaders prioritised physical security appropriately. Perimeter security technology required considerable maintenance and leaders liaised closely with contractors. There was now a more consistent approach to cell searching and it was properly prioritised.

3.34 Security processes were thorough and there was an excellent flow of intelligence, with 25 to 30 reports arriving at the security department every day. Intelligence was analysed and acted on promptly. Current security information was disseminated well, and the key issues and priorities were outlined in a clear monthly presentation.

3.35 Drugs were a prominent issue, and the positive rate of random drug testing was approaching 20%. Targeted suspicion drug testing achieved a disappointing positive rate of 25%. Many refused the test, choosing to take the consequences of refusal rather than have a positive test on their record. Cannabis and psychoactive substances were the main drugs used. The prison had good defences against the ingress of drugs through drones or throwovers, which meant that substances were likely to be entering the prison via visits, mail and staff. Prison managers liaised well with the police and a team within the security department focused on countering staff corruption.

3.36 However, there was no sufficiently focused planning to reduce the drug supply or demand. There had been a renewed emphasis on reducing demand, but there was a lack of dynamic leadership to make sure real progress was made.

3.37 Those with terrorist offences or links were managed carefully – there was an emphasis on caution and prevention, but also an individual approach involving work with the prisoner, in conjunction with psychologists and other professionals.

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

3.38 There had been eight self-inflicted deaths and two deaths from non-natural causes since our last inspection. Five of the self-inflicted deaths took place in 2018, one in 2019, and one in 2020 and one in 2022.

3.39 Leaders had addressed recommendations made by the Prisons and Probation Ombudsman (PPO), although assessment, care in custody and teamwork (ACCT) case management documentation for prisoners at risk of suicide or self-harm still required improvement.

3.40 The recorded rate of self-harm was the highest among similar prisons. The rate had doubled since our last inspection – in the 12 months before our last inspection, the rate of self-harm incidents per 1000 prisoners was 515 compared with 1013 incidents in the 12 months before this inspection. The number of incidents had been on a slight downward trajectory over the previous 12 months.

3.41 While a small number of prisoners accounted for a substantial proportion of incidents, 92 prisoners had self-harmed in the previous year. Long Lartin had the highest rate of individuals self-harming when compared with similar prisons. A third of men in segregation during our inspection were on open ACCTs, and one quarter of self-harm incidents in the previous year had taken place in the segregation unit.

3.42 There had been about 17 incidents of serious self-harm, but only three considered to have been life threatening had been investigated. The use of constant supervision was high – there had been 42 instances in the previous year, those we spoke to said it mostly consisted of an officer sitting outside the cell rather than any meaningful interaction.

3.43 Leaders had some insight into the reasons for self-harm, through consultation with peer mentors and Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners). Reasons included challenges with maintaining family ties, repercussions from being on the basic level of the incentives scheme and prolonged periods locked up with little to do. Leaders suggested that reduced key work delivery correlated with increased incidents of self-harm. However, drivers of self-harm had not been quantitatively analysed to provide an accurate insight into the prevalence and scale of some of these issues.

3.44 A range of data was routinely reviewed at monthly safer custody meetings, but they had not been used to underpin a strategic plan to

reduce self-harm or to review the effectiveness of any action. The safety strategy was not underpinned by any of these data.

3.45 Despite this, there were some ongoing initiatives to tackle self-harm. The SIM was held regularly and was well attended by stakeholders from across the prison. We found good examples of multidisciplinary work to support the individual care of some prisoners with complex needs. There had been some effective efforts to bring in families to support vulnerable men as part of their case management, for example arranging visits and involving family in ACCT reviews. After identifying cutting as one of the main methods of self-harm, leaders told us that a razor policy had been introduced, which meant disposable prison issue razors were no longer distributed and prisoners were provided with electric shavers instead.

3.46 In the previous 12 months, 174 ACCTs had been opened, and, during our inspection, 23 prisoners were on open ACCTs. The quality of ACCT documentation was variable – while they were adequately compiled, many had not drawn information into a coherent and meaningful plan that addressed the prisoners' underlying issues or reduced their risk of self-harm. Despite leaders putting structures in place, we came across instances of prisoners having a number of staff undertake their case reviews, which prisoners told us undermined their effectiveness. Prisoners we spoke to said ACCTs comprised of staff simply making observations of them. In our survey, only 31% of those who had been on ACCTs said they felt cared for by staff.

3.47 A proactive team of 16 Listeners received good support from the head of safety. Listeners were encouraged to walk about as part of their role, which was positive and allowed them to seek out prisoners who might benefit from their support. There was a lack of in-cell Samaritan phones for prisoners to use.

Protection of adults at risk (see Glossary)

3.48 Leaders did not have a direct link to the local adult safeguarding board, but they did have contact with the local council, although this was primarily focused on social care. There was a published social care and adult safeguarding policy, which included a shared memorandum of understanding with Worcestershire County Council and Practice Plus Group. Staff we spoke to did not know who the nominated lead for adult safeguarding was but said they would use the intelligence reporting system or refer prisoners to the safer custody team if they encountered any safeguarding concerns.

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, 71% of prisoners said staff treated them with respect, but only 34% said that a member of staff had checked on them in the previous week.

4.2 Prisoners were generally positive about staff. In particular, we found prisoners had good relationships with staff in some specialist functions, such as the gym or pre-psychologically informed planned environment unit (see paragraph 6.25).

4.3 We found, however, that many relationships between officers and prisoners lacked depth and most interactions we observed were cursory and transactional. Prisoners identified some staff who were less patient and empathetic with them. During periods of association, we observed staff supervising from a distance rather than interacting with prisoners. Prisoners also noted a lack of consistency – many staff were relatively new, and there was an intake of detached duty officers (those from other prisons) because of chronic staffing shortages.

4.4 The lack of key work sessions (see Glossary) exacerbated some of these negative experiences. We found that some of the sessions were good, but they were undermined because they took place so infrequently.

4.5 A few prisoners were peer mentors, including Listeners, who were well supported by leaders (see paragraph 3.47), and some who were part of the health champions programme, which was positive (see paragraph 4.40). Other peer workers, such as Shannon Trust mentors, had not been able to carry out their roles effectively because of the restricted regime. Many peer mentors we spoke to took pride in their roles in supporting their peers.

Daily life

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

Living conditions

4.6 Living conditions on the older wings remained inadequate, and most residential areas were dirty and poorly maintained even though most prisoners kept their own cell clean and tidy. Leaders had made some improvements, such as installing fitness equipment on wings and in exercise yards, adding curtains in cells, and putting robust but attractive furniture in association areas. Some shower rooms had also been refurbished. A number of the wing association areas were well equipped, which prisoners appreciated. The communal areas were, however, grubby, and some floors were in poor condition. In our survey, only 52%, compared with 71% at the previous inspection, said that the communal areas were normally clean.

General cell

On wing gym equipment

4.7 The backlog of repairs was high at 251 and had grown by more than half in the previous four months. There were some serious defects in the heating and hot water system during the inspection – large vents were jammed open, letting in cold air, and, in one case, rain and snow came through the roof vents. Many prisoners complained about shower temperatures being inconsistent and often too cold.

4.8 The night sanitation system remained on the older wings A to D, leaving half the accommodation without in-cell toilets or running water. Since the last inspection, the computerised system had been upgraded, allowing prisoners to press the button in their cell and join a queue for a 15-minute slot to use the toilet and showers. The technology was now working much more reliably, but the whole system remained unacceptable. Prisoners with no running water or toilet in their cell had to wait, normally, for at least for two hours and often much longer. They had a plastic bucket with lids in their cell, but they could not wash their hands after using it, and, very often, they tipped waste out of the window, as the smell became intolerable. Given the regime restrictions at the time of the inspection, those locked up for the morning or afternoon session remained reliant on the night sanitation system.

Night sanitation bucket

4.9 The problem of rats in the outside areas had become severe, and they could be seen running freely and in large numbers outside the houseblocks and in exercise yards.

4.10 An efficient electronic system was now recording the time taken for cell call bells to receive a response. Most were answered promptly, but delays of up to 20 minutes were not uncommon. In our survey, only 24% said their cell call bell was normally answered within five minutes, while, during our scrutiny visit in 2020, the figure had been 54%.

Residential services

4.11 The prison food was unpopular – only 24% of prisoners in our survey said the food was very or quite good. The main prison kitchen was dirty, in poor condition, and several pieces of equipment were out of order. We found bags of food waste spilling on to the floor and broken equipment lying around. The prison had faced challenges in getting enough kitchen workers to attend work and those working in the kitchen we spoke to shared their frustrations about the role.

Dirty and untidy kitchen

4.12 On most days, prisoners received their hot meal at lunch times and cold meals in the evening. The breakfast packs were served the night before and were meagre. Prisoners often received their cold meal at their door, which was not respectful.

4.13 Prisoners' negative perceptions of the food were partly offset by the on-wing self-catering facilities, which were greatly appreciated and well used. Nevertheless, there was a lot of broken equipment, including hobs and ovens that were not working. Supervision of these areas was limited. It was not clear how self-catering facilities accommodated prisoners with different dietary needs and we were not confident that all prisoners had equal access to them, particularly given the short periods of time they could spend unlocked.

Self-catering facilities

4.14 In our survey, 52% of prisoners said the shop provision catered for their needs. Leaders had carried out some consultation about the provision and had a good understanding of some of the issues prisoners faced. Nevertheless, many reported their frustrations about an increase in prices and supply issues. Leaders had made contingencies by purchasing frozen items when they were not available through the shop.

4.15 Prisoners could order items from a range of retailers, but the move to online purchases meant that many catalogues were not available, which made obtaining product codes and ordering items challenging.

Prisoner consultation, applications and redress

4.16 There were regular wing and prison-wide consultation meetings, which were well attended by managers. The governor, deputy governor and other senior managers attended the monthly prison consultative council. The prisoners who attended, well-established peer workers who kept in touch with a wide range of men on their wing, appreciated being given straight and authoritative answers to questions. However, the meetings were largely devoted to practical issues on the wings, which cropped up repeatedly, leaving no space for more constructive dialogue to develop. Prisoners were frustrated because these issues were not being resolved over many months.

4.17 Applications were still not tracked and there was no oversight of responses, which meant that prisoners often did not receive answers in a timely manner, or at all. Many prisoners told us they had little faith in the process. Plans were in place to introduce a system for tracking applications, but this work had not yet begun.

4.18 The prison had received over 3,000 complaints in the year leading to the inspection. Some related to minor issues that could have been resolved by an effectively functioning application system. At the outset of our inspection, complaint forms were not readily available on every wing. There had previously been persistent problems with responses to complaints being late, but a new system of oversight had addressed them, and most recent complaints had been answered in a timely manner.

4.19 Responses to complaints were variable, and some in the sample we reviewed were inadequate. We found responses that were abrupt and did not address the reason for the complaint, and in one instance, the person who was the subject of the complaint had written the response. The prison had recently had an external review of complaint responses which, alongside the improved quality assurance process, had led to some recent improvements.

4.20 Legal visits took place in private rooms, and booking arrangements were appropriate. A video link was available and was well used by prisoners. Prisoners who were registered as appellants (prisoners with ongoing legal issues, such as appeals and family court and immigration matters) could access additional phone services so they could contact their representatives. The prison's library contained a good selection of legal material and eligible prisoners could use laptops available through Access to Justice (a scheme enabling prisoners to have computers to assist their legal representations).

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

4.21 Despite equality and diversity being identified as a priority, the equalities team had not been adequately staffed, so progress in this area had been sporadic. Much of the action outlined in the minutes from equalities meetings was reactive, and there had been little progress against many more overarching objectives, which meant the work lacked strategic direction. Progress against some actions had been slow.

4.22 Leaders had collected some ~~useful~~ data on equality issues in the prison. However, analysis of this data was limited, and emerging issues were not promptly interrogated or followed up. There was little evidence to show how data were used to drive improvement across the prison.

4.23 There had been no consultation with prisoners with protected characteristics in the months leading to the inspection, and minutes from meetings, which had taken place with some groups earlier in the year, did not always record outcomes or action required. Prisoner equality representatives were in place, but several representatives told us they were unsure of what was required of them and did not have regular opportunities to discuss their work with staff. As a result, the experiences and needs of prisoners with protected characteristics were not clearly understood.

4.24 There had been 146 discrimination incident reporting forms (DIRFs) submitted in the year leading to the inspection, which was high. Many of the complaints did not relate to discrimination and were filtered out. Sixty incidents had been investigated. Investigations were adequate and responses appropriate in most cases. However, a small number of the responses we reviewed lacked empathy and did not demonstrate that investigations had been sufficient. Most were timely, although we found some cases where there had been lengthy delays.

Protected characteristics

4.25 About 40% of the prison's population were from black and minority ethnic communities, and there were 10 Gypsy, Roma or Traveller prisoners. There had been no regular consultation with these prisoners, and many told us that, while they had experienced little overt racism in the prison, they felt that staff did not always understand them and that better communication and opportunities to discuss their needs would have been helpful.

4.26 Twelve per cent of prisoners were foreign nationals. While it was positive that an immigration solicitor was scheduled to visit the prison shortly after our inspection, there had been little other specialist support available in the previous year. Foreign national prisoners with family overseas could add more money to their phone accounts so they could make international calls. Telephone interpretation was used on occasion for those who could not speak English, but we saw evidence that it was not always used when necessary. There was one immigration detainee at the prison during the inspection. His case was discussed at the monthly interdepartmental risk management meeting, but he had not received a visit from Home Office staff.

4.27 In our survey, 40% of prisoners said they considered themselves to have a disability. This group reported feeling less safe than prisoners without disabilities. The needs of those with physical disabilities were not always met. There were just two adapted cells, and neither of them were available for vulnerable prisoners. We spoke to prisoners who faced difficulties performing everyday tasks and who often relied on informal support from other prisoners. Some disabled prisoners had 'buddies' to provide care, but staff oversight was poor (see paragraph 4.50). There was no formal support for prisoners with neurodiversity, and some reported struggling to understand prison rules and interact with staff.

4.28 A new strategy to support young prisoners had recently been introduced but had not been implemented despite an increase in the number of younger prisoners since the last inspection. Twenty-one per cent of the prison population were over the age of 50. This group reported feeling more respected by staff in our survey than their younger counterparts. However, there was no needs analysis for older prisoners and specific activities, such as a garden project and library sessions, that were taking place during the previous inspection, were no longer offered.

4.29 In our survey, 4% of prisoners identified as being gay or bisexual, which differed from the data held by the prison. Prison staff were not clear on the number of prisoners who identified as LGBTQ and had identified this as an area that required development. Provision was limited – there had been no formal consultation, and we spoke to prisoners who reported ongoing problems, such as complaints relating directly to their sexuality that had not been resolved. No transgender prisoners had been held at Long Lartin in the year leading to the inspection, but a suitable policy was in place to support them should someone arrive.

Faith and religion

4.30 The well-established chaplaincy was fully staffed, and all main faith groups could attend regular weekly religious services. Prisoners from smaller faith groups received regular support. It was positive that vulnerable prisoners and the general population mixed in the chapel without issue, and that prisoners in the segregation unit could apply to attend the chapel on a risk-assessed basis.

4.31 The chaplaincy provided good individual support to prisoners who were bereaved, and, when appropriate, to those on open assessment, care in custody and teamwork (ACCT) case management documents for prisoners at risk of suicide or self-harm. However, the prison's regime had affected some areas of the chaplaincy's operations – religious study groups and group work for bereaved prisoners were suspended at the time of the inspection. The restricted regime also meant that some Muslim prisoners did not always have adequate time to wash before Friday prayers.

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.

4.32 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

4.33 Leadership and strategic oversight of health care arrangements were good. The head of health care, deputy head of health care and the business manager provided a committed, diligent and caring team with clear leadership and accountability. Partnership working between providers, the prison and stakeholders was effective and there were advanced plans to revive regular local delivery board meetings. A range of local and regional governance meetings provided services with good oversight.

4.34 We saw confirmation that lessons from incidents were learned, and a mature reporting culture was in place. In addition, we were provided with evidence that recommendations from Prisons and Probation Ombudsman reports received an appropriate response and action was tracked and monitored.

4.35 Staffing levels had been maintained despite recruitment and retention issues with the aid of regular agency staff and temporary workforce solutions. Mandatory training compliance was good, and all staff had access to clinical supervision and professional development, although the provider recognised the recording of clinical supervision needed to improve.

4.36 A monthly cycle of clinical audits was being undertaken and the results were driving service improvement.

4.37 Some rooms in the health care department did not meet infection prevention standards, but the provider was aware of the problem and leaders were formulating an action plan in response to a recent external infection control audit undertaken by NHS England.

4.38 There was an effective health care complaints system in place. All patients who made a complaint were seen face to face to seek a resolution. Complaint responses we sampled were respectful, addressed the issue raised and informed the patient of the escalation process if they remained dissatisfied.

4.39 Emergency resuscitation equipment was in good condition and daily equipment checks were completed. Some prison officers were unsure about where the emergency equipment was located. All defibrillators were stored behind a locked health care door, which had the potential to cause a delay to potentially life-saving treatment. An ambulance was automatically called when an emergency was relayed over the prison radio.

Promoting health and well-being

4.40 Health promotion activity followed an annual programme, which was organised through the patient engagement team and peer support health champions. Campaigns included a men's health awareness month, information on the risks and treatment of hepatitis C, mental health awareness and promotion of COVID-19 vaccinations.

Preventative screening programmes, including those for retinal and aortic abdominal aneurysm, were restarting. Health services were available, including drop-in clinics on the wings to encourage uptake of various health screenings. They had already identified patients with early hypertension, which might have gone unnoticed if the clinics had not been on the wing.

Primary care and inpatient services

4.41 On arrival, prisoners had an initial and secondary health screening. In the previous six months, the provider received 60 new receptions. It had met 100% of required initial screening targets as set out in the National Institute for Health and Care Excellence guidelines, and 100% of secondary screenings were carried out within seven days of a prisoner's arrival. Information about the care for prisoners who were transferred to other prisons was shared with the receiving health care team.

4.42 Waiting lists for GPs and allied health professionals were not excessive and urgent appointments were available. While current GP waiting times were growing due to a vacancy, the lists were regularly reviewed to check for any developing risks to those waiting. Two locum GPs were used to help reduce the lists while an additional GP was appointed.

4.43 The service identified and monitored patients with long-term conditions well. Some nurses had undertaken specific long-term conditions training, such as for asthma, and nurses worked with the GP and external specialists to make sure the approach was coordinated. This meant long-term conditions were well managed at the prison, and patients had timely reviews and support. Patients with complex needs were regularly reviewed through a strong multidisciplinary approach.

4.44 The inpatient department and end of life cell were not suitable. The fabric and condition of the cells was very poor. The ongoing admission of prisoners for operational reasons outside normal ward hours undermined the effective delivery of a therapeutic regime to clinically appropriate patients. We were told the inpatient unit was regularly used to house segregated prisoners.

4.45 We sampled digital clinical records on site. They were recorded at the time of treatment and key information was easily available. Health care staff knew their patients well and interactions we observed were courteous and respectful.

4.46 An excellent patient engagement team organised many activities and interventions to support patients throughout the prison. This team of staff and prisoner health champions provided an advice and liaison service, responding to patient enquiries and delivering health education and physical activity.

4.47 The management of delays to external appointments was variable. This was due to the staffing and operational requirements of the prison.

Effective administrative and clinical oversight made sure services were well placed to respond. Telephone consultations and clinical reviews with hospital specialists took place, supporting patients with additional reassurance.

Social care

4.48 There was an up-to-date memorandum of understanding and information sharing agreement between the health care department, the prison and Worcestershire County Council. The prison monitored social care assessment referrals to the council well and we were confident assessments took place in a timely manner.

4.49 One prisoner was receiving a formal social care package (see Glossary) and he was happy with his care and treatment, which was delivered by an external domiciliary care provider.

4.50 There was a lack of disabled cells in the prison and only one stairlift, which frequently broke down. The prison employed several 'buddies', but we were concerned there was no supervision or training provided and, we saw evidence of buddies providing intimate care, which was inappropriate.

Mental health care and substance misuse treatment

4.51 Inclusion, the mental health and substance misuse provider, ran a fully integrated team providing services for prisoners requiring support for both substance misuse and mental health problems, Monday to Friday. The service was well led and well organised, delivering effective oversight of care and robust governance arrangements, and staff had good access to training and supervision.

4.52 Prisoners were screened on arrival to identify any immediate needs and provide a response, including access to opiate substitution treatment. Everyone was seen during induction and provided with harm minimisation advice and informed about how to access all services. Prisoners could refer themselves directly to the service through a written application or by approaching members of the team on wings. Prison officers and other professionals could readily seek advice and request support for a prisoner. Support was also offered where a prisoner was suspected of misusing substances or had a positive drug test.

4.53 A comprehensive officer training package had been developed but had not been rolled out. Inclusion staff's relationships with health partners and the prison were generally good, and we saw examples of effective joint working during the inspection.

4.54 Clinical treatment for substance misuse was safe and delivered through a specialist nurse employed for two days a week. Sixteen patients were receiving opiate substitution therapy (OST) at the time of the inspection, most on a maintenance basis. Clinical support was jointly determined with the patient and reviews took place regularly with

appropriate input from Inclusion staff. All patients were prescribed methadone, but the team had not considered sufficiently the care requirements for prisoners arriving on other medicines, such as Buprenorphine prolonged release injection (used to treat opioid dependence), which needed to be re-evaluated.

4.55 Prisoners requiring psychosocial support for their substance misuse problems, or specialist input for mental health issues, all had their cases reviewed at a cohesive and structured multidisciplinary team meeting. All referrals were seen within five days, and an initial assessment was carried out by an assigned professional. A duty worker was available to see any patients making urgent requests for support. This included attending initial ACCT case management meetings for prisoners at risk of suicide or self-harm, offering ongoing support determined by the individual's needs. Records we sampled demonstrated good assessments, regular contact and clear, qualitative care plans.

4.56 The team had two nurse vacancies that had proved difficult to fill and was having an impact on specialist mental health input capacity. However, the team, which included psychiatry, psychology and therapy practitioners, worked very closely to make sure the range of interventions was appropriate for patients' needs. All patients had an allocated mental health care coordinator and caseloads were about 20 to 25 per practitioner, which was reasonable. The mental health caseload was about 114 for the whole team and 18 patients had a serious and enduring mental illness and were receiving effective care under the care programme approach. The mental health pathway provided interventions within a stepped care model (mental health services that address low level anxiety and depression through to severe and enduring needs) that included Improving Access to Psychological Therapy (IAPT) provision. There were some long waits before patients could access psychology-led support, but problems with the prison regime were creating the biggest hurdles to delivering more effective provision. Regime restrictions led to clinic access being curtailed, contact with prisoners on wings being periodically limited and staff being unable to coordinate therapeutic groups effectively.

4.57 Some patients requiring treatment in hospital under the Mental Health Act waited too long to be transferred, and three patients in the previous 12 months had to wait over three months to be moved, which was likely to have been harmful to their health and was unacceptable.

4.58 Fifty-seven prisoners were receiving psychosocial support specifically for drug and alcohol problems. The care provided and the general range of interventions was reasonable. Harm minimisation was offered at every contact and following any reported misuse. There were only two peer workers and no mutual aid groups, such as Alcoholics Anonymous or Narcotics Anonymous, and there were no plans to introduce this type of support, which needed to be reviewed.

4.59 The incentivised drug-free living wing provided the basis for a good service, but its effectiveness was limited, and its purpose undermined

because of regime restrictions – three segregated prisoners were held on the wing at the time of our inspection.

4.60 Few prisoners were released directly into the community, but we were confident any support needs would be met, such as through pre-release liaison with community agencies.

Medicines optimisation and pharmacy services

4.61 An external provider supplied medicines in a timely manner. Medicines administration on wings was led by nurses, who were sometimes supported by pharmacy technicians. Pharmacy technician support was currently limited due to staff shortages. A pharmacist was available in the prison part-time to support the health care team. The pharmacist clinically screened some prescriptions but did not routinely screen all of them. This meant their skills were not being fully used, and their full support and clinical oversight were not available to the wider health care team.

4.62 The pharmacy provided a stock of medicines that could be accessed in an emergency. The medicines were stored in a locked cabinet in the pharmacy and anyone holding health care keys could obtain them. Staff were asked to record anything retrieved from the cabinet, but they rarely recorded the medicines they took. This meant there was no audit trail or reconciliation of medicines accessed, who had accessed them and when, or which patient had been given the medicine. Some of the medicines were found in the treatment room on D wing. They were not labelled and there was no system in place for identifying or labelling emergency medicines as soon as possible after they had been supplied. This increased the risk of medicines being supplied incorrectly, given to the wrong person or being diverted or accessed inappropriately.

4.63 Prescribing and administration were recorded on SystmOne (the electronic clinical information system). Approximately 75% of prisoners were prescribed medicines in possession (IP). There was an IP policy in place and IP risk assessments were routinely carried out at reception and recorded on SystmOne. Some staff did not know how to access risk assessments during administration. Risk assessments were routinely reviewed after 12 months or if the person's circumstances changed. IP medicines were provided in clear plastic bags, which did not provide adequate confidentiality.

4.64 In the treatment room on D wing, non-IP medicines were stored in individually labelled trays. Some were labelled for individual patients' use. Several medicines were administered from stock, including all controlled drugs, which was not in accordance with current guidance or accepted best practice. Non-IP medicines were stored in a medicines trolley that was not appropriately secured after administration had been completed. Supervised medicine administration took place twice a day on all wings, at 7.45am and 5pm. The Friday evening round started at 3pm. Medicine administration was generally well managed, and queues were adequately supervised.

4.65 Some health products were on the shop list and a suitable stock of medicines was available to treat minor ailments without a prescription through patient group directions, or from a stock of general supply list discretionary medicines. Patients could receive these medicines for up to three days before being referred to a prescriber.

4.66 They could receive advice at the hatch or make an appointment to see the pharmacist, but there was no system in place to provide regular structured medicine reviews with the pharmacist. Patients had their medicines reviewed each year by an external provider, which involved little or no interaction with them, limiting their usefulness. There were well-attended regular medicines and therapeutics meetings, where the prescribing of abusable and high-cost medicines was monitored. Work had been undertaken to reduce the prescribing of tradeable medicines.

Dental services and oral health

4.67 A full range of dental treatments was available. Sessions were held each week and the team triaged those on waiting lists to prioritise urgent cases and schedule appointments according to patients' needs. During the inspection, only five patients were waiting for treatment, none of whom had waited longer than 28 days. The dental team was experienced and well established within the prison and well thought of by staff and patients. The dental suite was clean, equipment was well maintained, and there was a separate decontamination room.

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 A split regime had been operating at the prison for some time, which meant most prisoners were locked up either in the morning or afternoon. The many who were not working had two and a half hours out of cell, in addition to the time they spent collecting their meals. The scheduled time was two hours 40 minutes from Monday to Thursday, and two and a half hours on the other days. Those who were employed could have five hours out of their cell, with additional time to collect their meals. However, many prisoners said that these times were not consistently adhered to.

5.2 The response to the question about time out of cell at weekends in our survey was relatively negative – 40% of prisoners said they did not spend more than two hours out of their cell, compared with 20% in comparable prisons. On week days, 26% of respondents said they usually spent less than two hours out of their cell.

5.3 During our visit, a pilot scheme was taking place on wings C and D, in which the whole wing was unlocked to carry out domestic tasks and for association rather than half at a time, doubling the amount of time out of cell for those most disadvantaged by the cohorting arrangement.

5.4 Some evening association from 5pm until 6.30pm was being provided when staff numbers made it possible, which was welcomed, especially as the routine lock-up time of 4pm made it impossible for many prisoners, including those in prison jobs, to speak to their children and other family. However, prisoners complained not only about the short time spent out of their cells, but also the unpredictability of the regime, which was frequently subject to short notice and unplanned changes.

5.5 The exercise yards were adequate. During the inspection week, prisoners had no time in the open air on several days because of snow.

5.6 The library was laid out attractively – it had a good range of stock, including foreign language books and up-to-date legal texts, as well as topical displays. Library staff used Way Out TV (the prison's TV channel) to promote new books and encouraged prisoners to read through the Reading Ahead six-book scheme, for which take-up had been good. The Shannon Trust had trained several mentors to facilitate

peer-supported learning, but the scheme was still not very active at the time of the inspection (see paragraph 5.17). These positive initiatives were, however, totally undermined by the fact that hardly anyone could attend the library. In the week before the inspection, for example, when four sessions a day were programmed, prisoners had only attended two sessions, and this was not unusual. A lack of escort staff was the cause, with our survey reflecting this poor access – only 23% said they could visit the library once a week or more, compared with 72% in comparable prisons. The prison was failing to prioritise use of the library.

Library

5.7 Gym facilities, however, were being used frequently, seven days a week. Every prisoner could attend for three or four sessions a week, with an average of 27 per session. Staff were energetic and committed, and their work was complemented well by the health champions (see paragraph 4.40), who provided good support especially to those who were not used to visiting a gym or who needed extra support and encouragement. No accredited training was yet available, but instructors were preparing to deliver courses, particularly through the Active IQ awarding organisation.

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.

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

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Inadequate

Personal development: Inadequate

Leadership and management: Inadequate

5.9 Leaders and managers had developed an appropriate curriculum plan based on a thorough analysis of the needs of the prisoners. However, due to severe staff shortages, senior leaders did not provide prisoners with sufficient activity places in education, training and work. The regime was not predictable, and this had a negative impact on prisoners' attitude and progress.

5.10 This fundamental and pervasive problem meant that leaders had not successfully addressed six of the eight recommendations from the previous inspection. Leaders had, however, introduced a bespoke English course for speakers of other languages. Teachers planned the course well and adapted it to meet the needs of individual prisoners. At the time of the inspection, no prisoners had yet completed the course.

5.11 Leaders opened very few workshops for prisoners. Too many prisoners were involved in low-level jobs or wing work that was repetitive and failed to challenge them. Too many prisoners were engaged in wing cleaning. Managers did not monitor the quality standards of this work

well enough. As a result, too many men were demotivated and lacked a sense of purpose in their work.

5.12 Despite the efforts of prison leaders to improve access to education courses since October, it remained a challenge. Leaders did not provide sufficient places in mathematics or English. Waiting lists exceeded 60 prisoners for each. Leaders did not provide sufficient courses for prisoners who wished to study beyond level 2. Choices were too limited for vulnerable prisoners and consisted of one workshop and one small English class.

5.13 Too many prisoners were allocated to activities that did not align with their sentence plans or planned next steps. In work, too many prisoners did not develop their skills beyond the requirements of the job, and there was no clear plan for their next role in the prison. As a result, too many men remained in roles that did not develop their knowledge or skills.

5.14 The main prison education framework (PEF) provider, Milton Keynes College, did not provide a consistently strong educational experience. Teaching of the core subjects of English and mathematics was weak. Managers had not identified or addressed the key weaknesses through their own quality assurance processes. They had not provided recent staff training to improve teaching so that prisoners understood and remembered more. Teachers' planning and teaching were strong in art, music and in outreach work, but leaders had not shared good practice. Due to staffing issues at Milton Keynes College, there were no information technology or barbering courses. Managers had not used the lessons from the period of restrictions to establish resilient in-cell learning strategies to mitigate the impact of the disrupted regime.

5.15 While leaders and managers scrutinised the PEF provider's compliance with contracts and processes, insufficient time was spent on improving the quality of teaching or discussing the impact of staffing issues on the breadth of the curriculum on offer. As a result, while prison managers had a broadly realistic view of the strengths and weaknesses of their provision, they were too positive about the quality of education in mathematics and English and underplayed the impact of gaps in the curriculum on the prisoner experience.

5.16 In English and mathematics, teachers did not provide prisoners with a clear sense of how the curriculum fitted together. Too often individual lessons, based on worksheets, were not set in a broader narrative or context. As result, prisoners' experiences were disjointed. Prisoners retained little knowledge. Their records of learning were poorly organised and incomplete. Teachers did not use assessment well. Too often, past examination questions were used as the teaching resource rather than as a means of checking learning. Prisoners did not make good progress and too few achieved level 1 or level 2 functional skills qualifications in English and mathematics.

5.17 Milton Keynes College had provided the prison with a detailed prison-wide reading strategy. Leaders' own implementation plan lacked

enough detail, and there had been very little improvement in the reading levels of the weakest readers. Prison staff's actions were not well-coordinated, and staff were not clear about their role in the strategy. The prison leaders had invited the Shannon Trust into the prison. Fourteen prisoners had been trained as Shannon Trust mentors. Due to regime restrictions, they had only been able to support a few men (see paragraph 5.6). The college had estimated that about a third of the prison population were not strong readers. They had plans to start a specific course for non-readers and had worked with the library to purchase appropriate reading materials. The reading strategy had yet to have an impact on wider prison life or on prisoners in workshops.

5.18 In art and music, teachers planned carefully crafted courses, which built on prisoners' starting points and demonstrated clear progression when it came to establishing new skills and knowledge. Prisoners spoke with confidence and pride about their work, which was of a good standard. For example, in art, prisoners learned how to use different types of pencil to produce tone, texture and depth. They had won external awards for their work and were rightly proud of their achievements. In music, prisoners demonstrated pieces of music that they had composed, using software to produce multi-layered tracks with personal lyrics. Teachers in industrial cleaning combined theory and practice, and prisoners used these skills well when cleaning the education buildings.

5.19 The small number of prisoners on distance learning or Open University courses were supported well with administrative tasks, but due to regime restrictions, had not been taught how to improve their study or independent learning skills. They were making slow progress.

5.20 Prisoners in the kitchens and in industrial cleaning developed the skills they needed to carry out their jobs. Completions and achievements were high in food safety, principles of nutrition, on the NVQ in food preparation and cooking, and in cleaning. However, managers failed to make sure that the environment in the kitchen and on the wing was tidy and well ordered, which would have set high expectations that matched those found in this industry sector. Cleaners on the wings did not always wear appropriate personal protective equipment. Prisoners were not well-prepared for work in a professional environment.

5.21 Staff identified prisoners' additional needs well in education. They devised detailed support plans, which were used to help the learners to progress in education. However, staff did not provide prisoners who did not attend education with a specialist assessment or support to help them thrive in the prison.

5.22 While the pay policy did not discourage prisoners from attending education and work, attendance was too low, and punctuality was erratic. In classrooms and at work, prisoners showed respect for the teachers, trainers and their peers. They worked in a largely calm atmosphere.

5.23 Leaders and managers developed and used mentors and health champions well (see paragraphs 4.40 and 5.7). These prisoners worked in a range of settings, including in induction and workshops, on the wings and in the gym. The mentors helped other prisoners to improve their physical health and emotional well-being. However, leaders had not yet developed a common personal development curriculum across education and work. Managers had clear plans to celebrate a diverse range of events throughout the year. However, prisoners had not yet had formal opportunities to learn about equality and diversity or to gain an understanding of the significant changes within society.

5.24 At the time of the inspection, there was no specialist careers information, advice and guidance adviser. As a result, prisoners did not have access to independent high-quality advice or guidance. Temporary arrangements meant that trained prisoners undertook this role. During the inspection, inspectors observed that, while these men were well intentioned, the quality of advice and guidance was not consistently high, and the learning needs of some men were not identified.

Section 6 Rehabilitation and release planning

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

Children and families and contact with the outside world

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

6.1 The number of social visits spaces was sufficient, with facilities open for two and a half hours in the afternoon, four times a week, including weekends. Sessions could be booked by telephone or online, although the information provided to visitors on both systems was out of date. There continued to be a delay in start times for visits and during our inspection we saw one family waiting over one hour for their visit to start. Visitors told us this was not unusual and, in our survey, only 19% of prisoners said visits usually started and finished on time.

6.2 Family days had resumed earlier in the year and five had been held in the previous 12 months, with two more planned for the Christmas period. Staff from the Prison Advice and Care Trust (PACT) were involved in some activities, such as organising games for families and children. Although they were appreciated by those who attended, family days were limited in what they offered and were only delivered for two and a half hours, the same length as a standard visit.

6.3 The visitors' centre had been decorated to make it more child and family friendly, although the toilets were in a poor state. Artwork by prisoners' children was on display, and suitable information about what to expect during a visit was also available.

There was a wide range of activities for children of all ages in the visits hall, and we observed positive relationships between staff, prisoners and their families. However, closed visits could still not take place in private because there was no partitioning between booths. Most visitors we spoke to had long journeys to get to the prison, but the prison only offered a limited provision of cold food.

Visits play area

6.4 PACT staff provided some excellent support for prisoners' families. During our inspection, we saw a family member receiving support to get to the prison for a visit through funding obtained by the service. PACT also supported some complex prisoners, offering one-to-one parenting courses and attending the safety interventions meeting (SIM), contributing to care planning for a small number of individuals. (See paragraph 1.48.)

6.5 During our inspection, prisoners spoke to us about not receiving help to maintain family ties. The education department offered Storybook Dads (in which prisoners record a story for their children to listen to at home), but only two prisoners had participated in the previous year.

6.6 Regime curtailment meant restricted prisoner access to phones used to maintain family connections, and in-cell phones had not yet been installed. In our survey, only 79% said they could use the phone every day, compared with 93% at the last inspection. The video-calling service only provided half-hour slots per session and was further limited by connection issues and regime curtailments.

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 Nearly three-quarters of prisoners were serving life or indeterminate sentences for public protection and for those who had a recorded assessment, most were considered to present a high or very high risk. About one third of prisoners were category A status.

6.8 The prison did not have an up-to-date reducing reoffending strategy, action plan or needs analysis. Not everyone who was required to attended the reducing reoffending meetings, including the head of offender management services whose role should have been to act as the deputy chair. Meetings did not discuss all relevant pathways and action was outstanding from almost three years earlier. The offender management unit (OMU) policy had, however, been reviewed and there were plans to implement it in the near future.

6.9 There were gaps in the oversight and management of the OMU. There was no senior probation officer (SPO) based in the prison at the time of our inspection. Although there was probation management support from the community, leadership was inconsistent, and staff were working outside of their remit to cover this gap. The OMU team was an experienced and dedicated staff group, but staffing shortfalls resulted in low morale and a high workload. Time-bound tasks were prioritised, which meant other work, including one-to-one sessions with prisoners, was not part of POMs' everyday duties. Not enough was being done to make sure joint working across the prison was effective, which the POMs felt was affecting their work because of lack of information sharing.

6.10 Contact levels with prisoners were poor. In our case sample, we saw prisoners who had no contact with their POM in the previous 12 months. When contact was made, it was of a high standard, but some prisoners nevertheless felt neglected and unable to progress. On arrival at the prison, they were not always seen by a POM within a reasonable timeframe and were denied a specific offender management induction.

6.11 Key worker delivery was inadequate and did not support the offender management in custody (OMiC) model (see Glossary) (see paragraph 4.4). Of the cases we reviewed, prison recording systems showed all prisoners had an allocated key worker. Most of those interviewed knew who this was but they had minimal or no contact with them. Where key worker sessions did take place, records showed they mainly provided a commentary on the how the prisoner seemed rather than describing any meaningful engagement.

6.12 There continued to be a backlog of offender assessment system (OASys) reports as at previous inspections – 125 had not met the timescales required in the OMiC model. We found POMS considered risk factors well. Not all the reports we reviewed were updated after a significant change, and we found an assessment for a prisoner who had been recalled back to prison with a sentence plan that was community focused and irrelevant to his current circumstances. Too many prisoners were not aware of, or involved in, their sentence planning, and, in our survey, only 53% of prisoners knew they had a custody plan.

Public protection

6.13 The public protection policy was not up to date or tailored to the prison, but a review was currently underway. All new prisoners were screened thoroughly on arrival, initially by case administrators and then by POMs.

6.14 The interdepartmental risk management meeting (IRMM) had only resumed in May 2022 since the start of the pandemic. The IRMM was poorly attended and staff from other prison departments did not share information. A member of the security team, for example, did not always attend and during our inspection we saw limited communication from them with OMU staff. An ongoing action relating to risks to children were not addressed in a timely manner. A new public protection steering group had met once in the year, but no other meetings had been held – we were informed this was due to a lack of attendance.

6.15 Contribution forms (which share information) for multi-agency public protection arrangement (MAPPA) meetings that we looked at were mainly good, but some lacked sufficient detail. Due to the length of time left to serve, most of our sample group did not have a confirmed MAPPA level.

6.16 During the inspection, 73 prisoners were subject to child protection arrangements and 100 were on restrictions due to harassment. Monitoring arrangements were generally well managed and staff who were responsible for monitoring were experienced in these tasks. However, the visits booking clerks did not have access to the OMU database and managed their own list, which highlighted a lack of information sharing.

6.17 Risk management plans were of a mixed quality. We found some that contained old information that was not relevant to the prisoner's current circumstances or the provision at Long Lartin. Others clearly outlined ways of managing and mitigating prisoners' risks in custody and the community.

Categorisation and transfers

6.18 In the re-categorisation documents we reviewed, most assessments were timely, had logical approaches and were mainly well considered, with justifiable outcomes. However, there was not always evidence to show that the prisoner was involved or that they knew a review had taken place. Prisoners we spoke to said they were not asked for contributions or advised of the outcome of the reviews.

6.19 Over half the population had been at the prison for over two years and almost a third of prisoners for over four years. In our survey and during our inspection, prisoners expressed their dissatisfaction at not being able to complete accredited programmes or move to other prisons to complete interventions. This meant they were unable to demonstrate that they had reduced their risks so they could receive a lower categorisation (see paragraphs 6.21 to 6.23).

6.20 Due to population pressure, HM Prison and Probation Service had recently directed the prison not to move category C prisoners out of the establishment, which was affecting prisoners' progression. During our inspection, there were 12 category C prisoners, 10 of whom had been affected by the hold and two with specific needs who had waited over a year to progress.

Interventions

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

6.21 A range of accredited and non-accredited programmes was offered, and the prison had recently introduced a new in-depth needs analysis tool to support future planning. However, the prison did not meet the needs of all of the population and struggled to transfer prisoners to access programmes elsewhere.

6.22 The number of prisoners completing interventions was very small – only 14 prisoners had completed a programme in the previous year. Although robust plans were in place to increase participation, group sessions had been limited because of the restricted regime and some staffing vacancies. In the previous 12 months, only one group of nine prisoners had completed the Thinking Skills Programme and during our inspection another group of six prisoners was participating in the Motivation and Engagement programme. There were no group interventions for vulnerable prisoners, some of whom expressed their frustration about this during our inspection. The psychology and interventions teams undertook some good one-to-one work, but too few prisoners had the opportunity to take part.

6.23 Interventions were allocated on the basis of significant dates in a prisoner's sentence, limiting their opportunities for progression. During our inspection, category A prisoners were concerned because they had

to wait a significant period of time for a parole or release date before being able to complete a programme.

6.24 We saw the psychology department undertake some good work, and each wing had a dedicated psychologist as a single point of contact for support. They worked with several complex individuals across the prison, and we found some positive work being done in the segregation unit (see paragraph 3.31). A dedicated lead psychologist in the team oversaw the management of prisoners serving indeterminate sentences for public protection, which was positive.

Specialist units

Expected outcomes: Personality disorder units and therapeutic communities provide a safe, respectful and purposeful environment which allows prisoners to confront their offending behaviour.

6.25 The pre-psychologically informed planned environment (pre-PIPE) unit was for those assessed as suitable for PIPE but resistant to change. It offered a wide range of evidence-based therapeutic interventions, including structured one-to-one programmes, group work and enrichment activities. The unit was well run, with the programme length tailored to individual needs, and was not affected by regime curtailments. Most prisoners we spoke to were positive about the support they received.

6.26 The unit had some staff vacancies, but the prison was carrying out a recruitment drive. Prison staff were appropriately selected and interviewed to work in the pre-PIPE unit and national training was now available following a pause during the pandemic. Arrangements for individual and group supervision for prison and clinical staff were good, and staff we spoke to valued it. Clinical leadership was effective.

6.27 There were 14 places in the unit, and, during our inspection, 10 spaces were being used, and a further four prisoners were to be transferred to the unit. Outreach sessions were being delivered to help prepare those who were due to be moved to the pre-PIPE unit, which was positive. In the previous 12 months, five prisoners had successfully completed the programme, all of whom had been transferred to specialist units in other prisons. Four prisoners had been deselected and psychologists had supported them to reintegrate into the main prison.

Release planning

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

6.28 The number of prisoners being released from the prison into the community was low – only five in the previous 12 months had been released and four had been transferred to a secure hospital. There was no resettlement provision, but all prisoners were provided with appropriate accommodation, mainly to approved premises that were suited to their needs.

6.29 In the cases we reviewed, interactions with the community offender manager (COM) were adequate, handovers were completed by the POM and MAPPA levels were usually confirmed in a timely manner.

6.30 Finance, benefit and debt support was limited. The prison had recently seen a decline in the number of bank accounts being opened for prisoners due for release, and POMs tried to offer support, but not always with success. The education department offered a finance awareness course, with limited uptake.

Section 7 Summary of priority and key concerns

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

Priority concerns

1. **The level of self-harm had doubled since our last inspection and was the highest among comparable prisons, but there was no plan to reduce it.**

2. **Levels of violence were too high, especially against staff.** The safety team was under-resourced, and work to address the causes of violence remained limited.

3. **The prison's infrastructure was in very poor condition and in need of investment**. Many cells had no toilet or running water, and the heating, roofs, showers, kitchen equipment and some physical security systems were failing.

4. **Prisoners spent too much time locked up and the regime was delivered inconsistently.**

5. **Provision of education, training and work was insufficient, and prisoners were not allocated to courses that met their needs.**

6. **Prisoners had insufficient contact with offender managers to support risk reduction and sentence progression.**

Key concerns

7. **There was a high level of illicit drug use, but plans to reduce drug supply or to limit demand were lacking.**

8. **Too few key work sessions were being delivered, limiting staff-prisoner relationships and sentence progression.**

9. **The prison did not do enough to address perceived disproportionate treatment among those from ethnic and religious minorities or to cater for the prison's large number of disabled prisoners.**

10. **The health care inpatient unit and the end-of-life cell were not suitable and too many prisoners were placed in the unit inappropriately.**

11. **The shortage of pharmacy staff was affecting service delivery.** Prescribing was not subject to effective oversight or scrutiny, and governance of out-of-hours' medicines use was poor.

12. **There was not enough mathematics or English provision, and teaching standards in those subjects were poor.**

13. **Leaders had made insufficient progress in improving prisoners' reading levels.**

14. **Leaders had not developed a personal development curriculum across education and work.** Prisoners were not given formal opportunities to learn about equality, diversity or recent significant changes in society.

15. **There were shortfalls in public protection arrangements.** The interdepartmental risk management meeting was poorly attended and there was a lack of information sharing. Ongoing action relating to risks to children remained unresolved.

Section 8 Progress on recommendations from the last full inspection and scrutiny visit reports

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 2018, early days procedures were generally adequate. The prison housed a challenging, high risk population and there had been some very serious violent incidents, but there had been concerted action to reduce risks and improve procedures. At the time of inspection, the prison was stable and well controlled. Violence reduction procedures were very good. Force was used proportionately, but governance of special accommodation was poor. There was good work to move some challenging prisoners out of the segregation unit, but too many still spent long periods there. Security was generally proportionate and well managed. The number of prisoners who had harmed themselves had increased, but care for those at risk was very good. There had been excellent progress in implementing Prisons and Probation Ombudsman (PPO) recommendations. Outcomes for prisoners were reasonably good against this healthy prison test.

Recommendations

Prisoners' property should arrive with them on transfer or within a reasonable time after their arrival.
Not achieved

Wing staff should regularly check the welfare of new arrivals.
Achieved

Prisoners should receive a comprehensive and meaningful induction about the prison's rules and regime.
Not achieved

Prisoners on the basic level of the incentives scheme should be reviewed frequently and promoted to standard when there is evidence to show an improvement in behaviour.
Not achieved

Prison managers should fully investigate the reasons for the significant increase in the number of adjudications, and address any concerns identified.
Not achieved

Adjudications referred to the police should be followed up quickly to ensure natural justice for prisoners.
Achieved

Prison managers should investigate and address the reasons behind the increase in the use of force and special accommodation.
Not achieved

Managers should regularly review the video recordings of planned interventions.
Not achieved

Governance of the use of special accommodation should ensure that all uses are justified and properly documented, and that all procedures are correctly followed.
Achieved

Prisoners undergoing self-harm monitoring should only be held in the segregation unit in exceptional circumstances.
Partially achieved

There should be effective reintegration planning for all prisoners held in the segregation unit.
Achieved

Segregated prisoners should have daily access to showers and telephone calls, as well as a regime that provides more time out of cell if an individual risk assessment shows this is safe.
Not achieved

The visitors' dress code should be proportionate to the risks faced by the prison.
Not achieved

Mandatory drug testing facilities should be relocated to an appropriate testing and waiting environment.
Partially achieved

Prisoners should be able to access Listeners easily, including on reception and at night.
Partially achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection in 2018, staff-prisoner relationships were good. Living conditions were generally reasonable, but the night sanitation arrangements continued to be degrading and unacceptable. There were some weaknesses in complaints and applications procedures. Food was adequate and prisoners valued the opportunity to cook for themselves. Equality and diversity work had deteriorated, and potential disparities in treatment were not adequately identified or addressed. Faith provision was very good. Health services were reasonably good overall, but too many external appointments were cancelled, and the inpatient unit did not provide an effective therapeutic environment. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendation

A to D wings should be refurbished to include integral sanitation in cells.
Not achieved

Recommendations

All maintenance jobs should be completed swiftly and those of most importance to prisoner well-being and decency should be prioritised.
Not achieved

The prison should log and monitor responses to cell call bells.
Achieved

Breakfast packs should be issued on the day they are to be eaten.
Not achieved

Wing serveries should record food temperature checks consistently, and be cleaned after service, and prisoner kitchens on the wings should be kept clean and properly maintained.
Partially achieved

Prisoner consultation should be more widely promoted, and staff from all departments and representatives from each wing should attend meetings.
Achieved

Prisoner applications should be logged and tracked. Responses to applications should be prompt, address the issue raised, demonstrate sufficient enquiry and be subject to quality assurance.
Not achieved

Responses to all complaints should be timely and investigated at an appropriate level and should fully address the issues raised.
Partially achieved

The equality strategy should outline how the needs of all protected groups will be identified and addressed. It should be underpinned by regular consultation and accompanied by a systematically implemented action plan.
Not achieved

The national equality monitoring tool should cover all protected characteristics and produce data that is not more than a month old. The prison should use the available monitoring data and investigate any identified disparities.
Not achieved

Professional translation and interpreting services should be used to engage with foreign national prisoners who require them.
Partially achieved

The prison should develop a paid carer scheme to support prisoners with disabilities who needed extra support, and should make adapted cells available for vulnerable prisoners with identified needs.
Not achieved

The prison and health care staff should prioritise attendance at the planned local delivery board meetings to agree the key operational areas that require effective joint working.
Not achieved

Patients should be able to attend all necessary external health appointments.
Achieved

The inpatient service should operate through an agreed operational policy that that prioritises clinical need, and should deliver an effective therapeutic regime.
Not achieved

Prisoners accepted as needing transfer to hospital under the Mental Health Act should be moved within the Department of Health timescales.
Not achieved

Prisoners with substance misuse needs should be able to access groupwork as part of their programme of care and support, where indicated.
Not achieved

The in-possession medication policy should clearly identify the specific risks of drugs that could be tradable, and provide clear advice to prescribers.
Achieved

Purposeful activity

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

At the last inspection, in 2018, time out of cell for prisoners attending activities was reasonable, but during some of our roll checks we found more than a third of prisoners locked in cell during the working day. Access to association and exercise was reasonable, but the exercise period was too short. Most prisoners had access to reasonable gym and library services. New initiatives to develop activity provision had yet to be implemented, but some aspects of activities had improved and quality improvement arrangements were good. Most prisoners who took part in workshops and education were able to develop useful skills. Achievement of qualifications had improved and was good. Outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendation

The prison should ensure that there are sufficient activity places to occupy all prisoners fully during the working day, and that all those allocated to activities are able to attend.
Not achieved

Recommendations

Exercise should be offered for an hour a day.
Achieved

All prisoners should have equitable access to PE facilities and qualifications.
Partially achieved

There should be sufficient higher level courses to meet the learning needs and aspirations of prisoners, especially those serving long sentences.
Not achieved

There should be structured provision of English for speakers of other languages (ESOL), and English and mathematics support should be included in all workshops as part of prisoner learning.
Partially achieved

All prisoners, including vulnerable prisoners, should have access to the ‘virtual campus’.
Not achieved

The results of prisoners’ initial assessment of English and mathematics support needs should be routinely shared with staff in the workshops to help plan individual learning.
Partially achieved

Equality and respect for diversity should be promoted and reinforced in the workshops and training areas.
Not achieved

Trainers should record development of prisoners' personal, social and work skills to ensure that they are better prepared for progression to further education and training.
Not achieved

The prison should provide a sufficient range and quality of accredited work and vocational training to develop prisoners' work skills and ensure recognition of their achievements.
Not achieved

Rehabilitation and release planning

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

At the last inspection, in 2018, there was very limited family support provision. Visits were relaxed but often started late. There was an ongoing shortage of offender supervisor time, and rehabilitation services were not sufficiently well coordinated. There was a backlog of offender assessment system (OASys) assessments, but the quality was good. Public protection procedures were very good. A high number of prisoners completed offending behaviour programmes. Many prisoners achieved progressive transfers. Release was well managed. Outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendation

The prison should provide a comprehensive range of support to help prisoners sustain and improve relationships with their children and other close family members.
Partially achieved

Recommendations

Visits should start at the advertised time, and prisoners should be able to have closed visits in privacy.
Not achieved

There should be a supervised children's play area in the visits hall, and a wide range of food and drinks for visitors.
Partially achieved

Offender supervisors should have sufficient time to undertake their roles in full. They should receive necessary training and supervision, and an offender management policy should outline how their work is to be integrated with other departments.
No longer relevant

OASys assessments should be completed promptly, including by community offender managers.
Not achieved

Child protection training should be available for all staff, with priority for staff who have direct contact with children.
Partially achieved

Recommendations from the scrutiny visit

The following is a list of the recommendations made in the scrutiny visit report from February 2021.

Leaders and managers should revise the oversight arrangements across the establishment so that their purpose is clear and their oversight sufficiently robust to ensure improved practice.
Achieved

Force should only be used as a last resort and when necessary and proportionate. All force should be recorded accurately and subject to oversight.
Not achieved

Prisoners who require segregation should only be segregated for as long as is necessary and have a reintegration plan. Relationships between staff and prisoners should be improved and prisoners should have daily access to telephones and showers.
Partially achieved

All prisoner complaints should be investigated thoroughly. The issues should be appropriately addressed and the response should be transparent and independent.
Not achieved

The governor should take immediate action to make sure his approach to promoting equality is underpinned by systematic monitoring and analysis of outcomes for prisoners in each protected characteristic group, supporting an effective system for the reporting and investigation of complaints about discrimination.
Not achieved

The prison should work with health providers to manage prisoner access to health professionals and individual patient risks safely, and to reduce health care waiting times.
Achieved

Medicines should be administered to patients in the safest way, meeting professional and good practice standards.
Not achieved

Prison leaders should make sure that all public protection monitoring takes place promptly.
Achieved

Appendix I About our inspections and reports

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

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

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

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

Respect
Prisoners are treated with respect for their human dignity.

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

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

Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. There are four possible judgements: in some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by His 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
Sara Pennington	Team leader
Sumayyah Hassam	Inspector
Martin Kettle	Inspector
Rebecca Mavin	Inspector
Chelsey Pattison	Inspector
Paul Rowlands	Inspector
Dionne Walker	Inspector
Emma King	Researcher
Sophie Riley	Researcher
Joe Simmonds	Researcher
Reanna Walton	Researcher
Shaun Thomson	Lead health and social care inspector
Stephen Eley	Health and social care inspector
Chris Barnes	Pharmacist
Mark Griffiths	Care Quality Commission inspector
Carolyn Brownsea	Ofsted inspector
Mary Devane	Ofsted inspector
Diane Koppit	Ofsted inspector
Martin 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 in the women's estate for eligible women and is one element of the Offender Management in Custody (OMiC) model. All prison officers have a caseload of around six prisoners. The aim is to enable staff to develop constructive, motivational relationships with prisoners, which can support and encourage them to work towards positive rehabilitative goals.

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

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

Pathways to Progression
A joint operational and clinical approach to managing complex custodial behaviour with the aim of reducing the number of prisoners segregated for long periods in the long-term and high security estate (LTHSE).

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

Protection of adults at risk
Safeguarding duties apply to an adult who:

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

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

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

Appendix III Further resources

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

Prison population profile

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

Prisoner survey methodology and results

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

Prison staff survey

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

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

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

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