

Report on an unannounced inspection of

HMP/YOI Brinsford

by HM Chief Inspector of Prisons

5-16 June 2023



Contents

Introductio	n		3
What needs to improve at HMP/YOI Brinsford			5
About HMP/YOI Brinsford			7
Section 1	Summary of key findings		
Section 2	Leadership		11
Section 3	Safety		
Section 4	Respect		23
Section 5	Purposeful activity		39
Section 6	Rehabilitation and release planning		47
Section 7	Progress on recommendations from the last full inspection		54
	Appendix I	About our inspections and reports	57
	Appendix II	Glossary	60
	Appendix III	Further resources	62

Introduction

When we inspected Brinsford in August 2021 we raised concerns about the amount of time that the 517 young men at the prison were spending out of their cells. On this inspection we found a slightly improved picture with more prisoners in at least part-time work, but our score of 'poor' for purposeful activity reflects a jail that still has a long way to go.

The prison was held back by a culture among a significant minority of staff and middle managers that Brinsford prisoners were so risky that it was better to keep them locked behind their doors, where too many continued to spend their days sleeping and watching television. This attitude remained a huge block to the ambition of the governor, and she will need to take on these influential vested interests if the jail is to make further progress.

An example of this inertia was the use of force: at our last inspection, we criticised poor governance and in particular the apparent reluctance of staff to turn on body-worn cameras. Since then, the prison had acquired enough new cameras for every staff member, but leaders had not done enough to make sure they were activated. Too often the only footage we were able to view was taken when the prisoner was being returned to his cell, rather than at the beginning of the incident. In other jails, where leaders have been more resolute, we have found that the use of body-worn cameras has become embedded.

Teachers told me that they were frustrated that only a small and unpredictable number of students turned up to education, not because they did not want to come, but because getting them to the education block was not seen as a priority by some staff. Not enough work had been done to improve on some of findings from 2021, and none of the recommendations in this area had been fulfilled. It had taken too long to create a prison-wide reading strategy, assessment was weak and peer mentor support was very limited. Prisoners told me that sometimes, when they did get to education, they discovered it had been cancelled. This negative attitude also meant that men were often not taken to important health care appointments.

We continued to be concerned about levels of violence, which remained too high and led to regime restrictions. This, in turn, also fed boredom, a sense of helplessness and a lack of motivation among prisoners – factors which were themselves drivers of violence. We were pleased to see that the governor and her senior team had brought in some new ways of motivating good behaviour such as increased gym time, association, and sporting events, although rewards that had been earned were not consistently delivered.

There was huge potential among the young men in the prison, but not enough had been made of the large grounds and in developing other facilities to make sure that they were expending their energy in more positive ways. Although we criticised the fabric of the prison at our last inspection, it continued to be substandard, apart from the refurbishment of some wings and showers. Unscreened lavatories were stained, there was toothpaste over many of the

walls, and the redecoration initiative involving a party of prisoners seemed to have spattered almost as much paint on the floor as on the walls.

The induction wing needed some serious managerial grip. One young adult I spoke to, who had arrived into prison for the first time two days before, found himself in a cell that had someone else's tissues and a desiccated apple lying on the floor, a pair of trainers left by another prisoner and no duvet cover; sadly this was not untypical. This was not acceptable, nor was the lack of a proper induction for many new prisoners.

The offender management unit continued to be a strength of the prison with a team of well-led, motivated staff providing a good and consistent service to prisoners. There continued to be concerns with public protection arrangements, which meant there was the potential for some prisoners to be released without proper consideration or planning around their risk level in the community.

In the 22 months since our last inspection, Brinsford had not made the progress we would expect, although there were some pockets of good work, such as the appointment of two external members to the leadership team to help understand the prisoner experience, family engagement for prisoners in crisis and initiatives such as the Acorn centre and segregation learning suite to encourage positive behaviour.

Now there is a more stable senior management team in place, and the governor is well-established in her role, there is the opportunity to use this latest report to drive forward progress. The challenge is for the senior leadership team to consolidate the small improvement we identify in this report, provide consistent and clear direction for staff and apply real rigour elsewhere to make sure that Brinsford becomes a safe and decent prison.

Charlie Taylor HM Chief Inspector of Prisons July 2023

What needs to improve at HMP/YOI Brinsford

During this inspection we identified 13 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. Leaders had not done enough to address the negative attitude of a significant minority of staff and some managers, which was hampering progress in many parts of the jail.
- 2. Levels of violence were too high.
- 3. Governance, oversight and practice of the use of force continued to be very poor.
- 4. Leaders had not set a high enough standard for living conditions. Communal areas had been neglected, and prisoners lived in austere conditions and struggled to get access to basic supplies. This was particularly unwelcoming for new arrivals who were met with messy and indecent cells.
- 5. Leaders were not providing enough full-time activity spaces for prisoners, and too many were stuck in their cells with nothing to do.
- 6. **Prisoners' attendance rates at education, skills and work were too low, and had not improved over time.** Too few prisoners had positive attitudes towards education and work.

Key concerns

- 7. Prisoners' experience during their early days required improvement.
- 8. Patients lacked consistent access to clinical services, which meant they were not being assessed in a timely manner.
- 9. Patients did not receive their medication in line with national standards or in such a way that the optimum therapeutic effect was achieved.
- 10. Patients experienced long delays before they were transferred to a mental health hospital, preventing them from having prompt access to specialist care.

- 11. Too few prisoners developed the mathematical and English knowledge that they needed for their future careers. The prison's reading strategy had had little impact on the many prisoners with low levels of reading ability.
- 12. **Teachers did not plan the content of their curriculums well enough.** In too many cases they did not consider the knowledge, skills or attitudes that prisoners most needed.
- 13. Public protection arrangements to prepare for the release of prisoners who presented a risk to others were not sufficient.

About HMP/YOI Brinsford

Task of the prison/establishment

A resettlement and reception prison for young adults on remand and men aged 18-29 from the West Midlands.

Certified normal accommodation and operational capacity (see Glossary)

Prisoners held at the time of inspection: 517 Baseline certified normal capacity: 539 In-use certified normal capacity: 539

Operational capacity: 577

Population of the prison

- 1,094 men were received in the previous year 447 were from court, 518 were those who had been transferred from another prison, 126 had been recalled from the community, while three had been recalled while on home detention curfew.
- There were 67 foreign national prisoners (13% of the population).
- 46% of prisoners were from a black and minority ethnic background.
- 56 prisoners were receiving treatment for substance misuse.
- 56 prisoners had been referred for mental health assessment in the previous month.

Prison status and key providers

Public

Physical health provider: Practice Plus Group (PPG)

Mental health and substance misuse treatment provider: Inclusion

(subcontracted by PPG)

Dental health provider: J. Hear and Partners Prison education framework provider: Novus

Escort contractor: GEOAmey

Prison group

West Midlands

Prison Group Director

Teresa Clarke

Brief history

Brinsford opened as a young adult offender institution and remand centre in November 1991. It is on the same site as HMPs Featherstone and Oakwood. In 2008, the prison established a fifth residential unit and in 2009, the Rowan Activities Centre opened. In November 2013, Brinsford underwent a programme to refurbish residential units 1 to 4. The establishment's role changed in 2016, to accommodate a mixed population of young adults and sentenced category C adults.

Short description of residential units

Unit 1 – early days in custody, induction and development progression units Units 2–4 – residential living unit Unit 5 – resettlement unit Unit 6 – incentivised substance-free living unit Inpatient unit Segregation unit

Name of governor and date in post

Amanda Hughes, July 2020

Independent Monitoring Board chair

Pauline Hirons

Date of last inspection

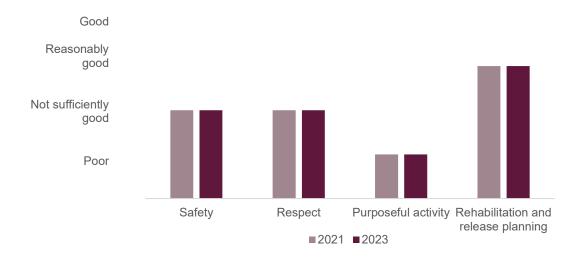
16 and 23-27 August 2021

Section 1 Summary of key findings

Outcomes for prisoners

- 1.1 We assess outcomes for prisoners against four healthy prison tests: safety, respect, purposeful activity, and rehabilitation and release planning (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).
- 1.2 At this inspection of HMP/YOI Brinsford we found that outcomes for prisoners were:
 - not sufficiently good for safety
 - not sufficiently good for respect
 - poor for purposeful activity
 - reasonably good for rehabilitation and release planning.
- 1.3 We last inspected HMP/YOI Brinsford in 2021. Figure 1 shows how outcomes for prisoners have changed since the last inspection.

Figure 1: HMP/YOI Brinsford prisoner outcomes by healthy prison area, 2021 and 2023



Progress on key concerns and recommendations

- 1.4 At our last inspection in 2021 we made 15 recommendations, 13 of which were about areas of key concern. The prison fully accepted 13 of the recommendations and partially (or subject to resources) accepted two.
- 1.5 At this inspection we found that four of our recommendations about areas of key concern had been achieved, one had been partially achieved and eight had not been achieved. One of the recommendations made in the area of safety had been partially achieved, while three had not been achieved. In the area of respect,

one recommendation had been achieved and one had not. In the area of purposeful activity, two recommendations had been achieved and four had not. The recommendation made in rehabilitation and release planning had been achieved. For a full list of the progress against the recommendations, please see Section 7.

Notable positive practice

- 1.6 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.
- 1.7 Inspectors found two examples of notable positive practice during this inspection.
- 1.8 Two external non-executive members had been appointed to the senior leadership team. Both were young Black men, one of whom had experienced prison life. The initiative aimed to help leaders better understand prisoners' experiences and perspectives. (See paragraphs 2.9 and 4.35.)
- 1.9 A patient with autism had received tailored support from health care and prison staff so he could safely and effectively manage his medication in possession. (See paragraph 4.83.)

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 The governor had been in post since 2020, but nearly all the senior team had been appointed in the months before and following the last inspection in August 2021. However, a more consistent and stable leadership team had begun to make some improvements in the prison.
- 2.3 The self-assessment report did not fully reflect a true picture of the prison and was particularly overambitious in areas of safety such as the early days experience, processes to manage violence and the governance of body worn video cameras. The governor had revised the prison's priorities, which were designed to be easy for all to understand and aligned to the key challenges that the prison faced. Nevertheless, they lacked depth, and no specific measurable action was outlined to make the improvements needed.
- 2.4 Despite the simplicity of the priorities, which were based on leadership, safety and activity, the staff survey showed that only half of respondents thought they were clearly communicated.
- 2.5 Leaders had introduced new ways of promoting positive behaviour. However, the culture of the prison remained too restrictive. There was a lack of trust and an over-reliance on 'keep apart' lists, where prisoners were not able to mix with others with whom they are in conflict (see paragraphs 3.35 and 6.5). As in 2021, and despite improved staffing levels and good retention rates, a risk averse culture was affecting outcomes across all four healthy prison tests. For example, leaders did not provide a full regime, too few prisoners attended purposeful activity, and time out of cell for most was inadequate, all of which limited prisoners' opportunities for rehabilitation.
- 2.6 The senior team fully understood what was required to improve outcomes for prisoners, but not enough had been done to address the behaviour of some middle managers which was affecting progress in a number of areas. Leaders of all grades, including custodial managers, were not visible enough across the prison.
- 2.7 A third of prison officers had less than two years' experience. While prisoners reported mostly positive interactions with staff, leaders had not made sure that officers understood the importance of facilitating a purposeful regime, underpinned by safe and decent living conditions.

- 2.8 While safety was identified as a priority by the governor, violence remained too high, and leaders were not aware of some main issues, such as the overreliance on the use of PAVA incapacitant spray. Despite being raised at our last inspection, body-worn video cameras (BWVCs) were still not used routinely, and they were used the least often compared with other prisons we have seen, despite the deployment of new and improved BWVCs six months previously.
- 2.9 Leaders had work to make sure that joint working with the police, health care staff and resettlement partners was strong. The recent appointment of two black and minority ethnic non-executive members to the senior leadership team to help challenge leaders' decision making was an innovative development (see paragraphs 1.8 and 4.35). We also identified effective leadership in the offender management unit and the safety hub, and the drug strategy and welfare teams all had individual managers who were motivated and performing well. Leaders had made good use of data in some functions but had not been sufficiently rigorous in key areas, such as the use of force and reducing reoffending.
- 2.10 Brinsford was a challenging prison to run, where inspection outcomes had stalled over the past 10 years. This could, in part, be traced to a risk-averse culture. Despite the slow progress identified at this inspection, there was evidence that leaders were beginning to address some of our concerns. For example, the recent review of the prison's culture and associated action plan showed promise, as did the new leadership commitment to improve the core day and access to activity.

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 Brinsford received about 90 new arrivals a month and there were 50 releases into the community. All new arrivals were routinely stripsearched, and body scanned without there having been any evidence of an individual risk assessment taking place. Even prisoners who had been transferred from other establishments had to undergo these processes, despite having already been subjected to them on their departure.
- 3.2 Prisoners generally arrived with the correct information about their potential risks or vulnerabilities. Processes to identify vulnerability on arrival were in place and a nurse carried out a health screening while an induction officer conducted a safety interview.
- 3.3 Despite this, support for prisoners in their early days was not good enough. In our survey, prisoners were much more negative about their experiences in reception than those in other similar prisons.
- 3.4 The communal area of the reception building was bright and welcoming, but the holding rooms were bare and dirty. There were no photos or posters on display to promote the opportunities available to help motivate prisoners. However, the positive atmosphere created by reception staff meant newly arriving prisoners received a friendly welcome. Prisoners sat in an open plan, communal lounge area where they could eat their food and interact with reception staff and one another. This was particularly helpful when there were delays in moving prisoners to the induction unit.



Communal area in reception

- In our survey, fewer prisoners than at the last inspection (41% compared with 61%) said they had been offered a shower on their first night. Only a minority of prisoners (19%) reported having phone numbers approved within 24 hours, compared with 36% in similar prisons. We spoke to prisoners who complained about not having been able to ring their family several days after their arrival.
- 3.6 A reception booklet with information about prison life was available and had been translated into a few languages, but professional telephone interpretation services were not used for non-English speaking prisoners and reception staff did not know how to access the resource.
- 3.7 New prisoners were located in the induction unit, which had moved since our last inspection and was now in residential unit 1. First night cells were not clean or in good order and not all prisoners were provided with basic items. Only 27% of respondents in our survey said their cell was clean compared with 49% of those in other similar prisons. We found cells that were dirty and had excessively stained toilets. A number had no pillowcases or duvet covers and the previous occupants' items had not been removed from others. Leaders were not aware of the conditions of induction cells, which demonstrated that there were insufficient quality assurance checks. The regime in the first night centre was poor, and most prisoners received only about one hour a day out of their cells.



Toilet in empty cell on induction unit

- 3.8 A prison induction programme had been drawn up and two peer supporters appointed, but it was often cancelled. During the inspection, six prisoners who had arrived on our first day had not received an induction until we raised it at the end of the third day. Prisoners were often moved from the induction wing without having received an adequate induction to the prison.
- 3.9 Although new arrivals were offered packs containing vapes and basic groceries, delays in receiving their first prison shop order meant many could not buy further items for over a week, sometimes for up to two weeks. This caused frustration and increased the risk of prisoners getting into debt.
- 3.10 There was no peer support during prisoners' early days, for example Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners). It was positive that staff conducted regular overnight well-being observations of new arrivals for their first three nights.

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

- In our survey, 16% of prisoners said they felt unsafe at the time of the inspection. Almost half the population (47%) said they had felt unsafe at some time, which was high. For prisoners under 21, the figure was 60%, which was higher than for those over that age (32%).
- 3.12 The recorded rate of violence between prisoners had increased significantly since our last inspection by just under 50%. In the previous 12 months, there had been 397 recorded incidents, which was high when compared to prisons with a similar population or category. The rate of assaults on staff was comparable to the last inspection, with 30 recorded incidents in the previous year, which was lower than in similar prisons. Seven per cent of all incidents had been classified as serious, but leaders did not investigate them to learn lessons that would support a reduction in violence.
- 3.13 Challenge, support, and intervention plans (CSIPs) (see Glossary) were not timely or of sufficient quality. Investigations were sometimes poor and failed to establish the cause of the incident. Care plans were often generic and did not sufficiently address the individual's needs. While staff and prisoners were aware of the CSIPs in place, both had limited knowledge of what was contained in the plan or its purpose.
- 3.14 Leaders had undertaken some promising consultation into the causes of violence including a prisoner survey and focus group meetings, but the lack of investigation into the causes behind incidents limited leaders' understanding of violence. Leaders had used the consultation to revise the current safety strategy, which was under review at the time of the inspection.
- 3.15 There were several initiatives to promote a safer prison. They included using conflict coaches, prisoners trained to manage conflict. Those in this role were positive and felt supported by the safety team. However, nearly all stated they could have been used more often, but because residential staff failed to assist them and movements around the prison were restricted, they could only support prisoners on the unit on which they lived, which limited their effectiveness. Other initiatives included creating a 'safety wing of the week', which offered prisoners an extra gym session at weekends to the winners, but it was too early to assess the impact on safety. The prison's inspirational speakers and events programme, focusing on the effect of using weapons, received positive feedback from prisoners.

3.16 An incentives scheme was in place – it emphasised promoting and rewarding positive behaviour. On the higher level, leaders offered incentives, such as more time out of cell and the opportunity to live in residential unit 5, which had recently been designated as the resettlement unit and provided an enhanced living environment with even more time unlocked. They also included weekly access to the Acorn Centre, a recreational space away from the residential units. Prisoners were positive about the benefits of being on the enhanced level of the scheme.



The Acorn unit

3.17 There was appropriate oversight to make sure that prisoners on the lowest level of privileges received timely reviews and any who remained on basic for longer than 14 days were referred to the weekly safety meeting. However, behaviour targets were not set during reviews, and there was no process for tracking warnings, either positive or negative, to establish if staff were using them appropriately.

Adjudications

- 3.18 The number of adjudications had increased by 50% since the last inspection and, in the previous 12 months, there had been 2479 charges against prisoners for breaching prison rules. Part of the increase could be attributed to restarting drug testing and a rise in the level of violence.
- 3.19 We found charges that we reviewed were appropriately laid, and subsequent sanctions were proportionate. However, adjudicators did not always demonstrate whether cases had been fully investigated before a verdict had been reached. There was no quality assurance in place, which meant it was difficult to identify and address weaknesses.

3.20 A weekly 'crime clinic', involving prison staff and the police, made sure the most serious charges were managed effectively.

Use of force

- 3.21 Recorded incidents involving force had increased by 24% from 520 to 771 over a 12-month period since the previous inspection. The prison did not keep records of how many incidents had been escalated to include the use of full restraint or how many were guiding holds only, but 284 involved using ratchet bar handcuffs. Nearly all instances were unplanned, and most were to prevent a further escalation of violence between prisoners.
- 3.22 Documentation for the use of force was mostly completed promptly, but justifications for the use of force were variable and did not always outline attempts to de-escalate the situation.
- 3.23 Recording of incidents of force through body-worn video cameras (BWVCs) continued to be very poor and was among the worst we had seen. Of the 771 incidents of force, BWVCs had only been turned on in 70 cases, and many of those did not capture the full incident.
- 3.24 Leaders attributed this to the introduction of new and improved BWVCs in late 2023, but their use had not improved, and we identified serious incidents that took place during our visit, for which no footage was available. Leaders had not challenged officers' failure to activate BWVCs during incidents effectively enough.
- The prison had introduced PAVA incapacitant spray. PAVA was used frequently, and, in a 12-month period, 74 prisoners had been sprayed, which was much higher than we normally see. Of the limited footage available, we observed that the deployment of PAVA was not always a last resort. In some cases, we saw it being used recklessly and freely, inappropriately targeting several prisoners, including those not involved, and affecting many members of staff. In other cases, other options could have been explored instead, such as restraint holds. Batons had also been used on 18 prisoners over the same 12-month period.
- 3.26 Investigations into every PAVA and baton use had not been conducted and leaders did not effectively identify lessons to be learnt to support a reduction in such extreme use of force.
- 3.27 Governance of force continued to be poor. Structures were developing, such as a weekly scrutiny meeting and a monthly strategic meeting, but they had only been established within the previous six months, were not held regularly and were yet to be effective. Systems were not in place to make sure force used was proportionate, necessary, and only used as a last resort. Where concerns were identified, there was no evidence that appropriate steps were taken to make sure lessons were learned or to reduce the likelihood of further incidents of force taking place.

3.28 Leaders had identified that some prisoners were overrepresented in incidents involving force, for example those from protected characteristic groups, such as black and minority ethnic prisoners and those under the age of 21 and were exploring this further. Several forums had been held and an in-depth review of the use of force had been conducted, but it was too soon to identify any change in outcomes.

Segregation

- 3.29 Levels of segregation had increased since the last inspection, but most stays were short at about six days. Too many prisoners were segregated pending adjudication more than half of all stays were for this reason, but leaders did not document the justification for the decision to segregate prisoners in these cases.
- 3.30 The daily regime in the unit remained too limited prisoners were offered a shower and time in the open area every day, which meant most were confined to their cells for 23 hours a day. A learning suite had recently been introduced in the unit, which gave them access to a laptop so they could take self-development courses, such as CV writing. While it was not fully embedded in the three weeks it had been open, 25 hours of development time had been delivered, from which some prisoners had benefited.



Learning suite

3.31 Standards in the accommodation had improved since our last inspection – prisoners now had phones in their cells on arrival, but there was still some graffiti.

3.32 Paperwork for segregation was poor – hourly observations of prisoners were either not recorded or did not take place. There were limited documented meaningful interactions, for example, daily visits from statutory visitors only stated that the prisoner had raised no concerns. Prisoners we spoke to were positive about how they were dealt with in segregation, and in our survey, three quarters of them said staff treated them well.

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 Intelligence was managed very well. The security department received over 400 information reports a month, which were promptly analysed through the regional intelligence hub. Action in response to intelligence, such as suspicion drug testing and targeted searching, was swift. In the previous six months, for example, 74 suspicion-led searches had been conducted, of which 70% resulted in finds of contraband or led to further intelligence.
- 3.34 Links to the West Midlands Police were good and a full-time liaison officer was based in the prison. A joint effort to help manage organised crime gang members was good and further supported by tailored intelligence reports from the regional hub.
- 3.35 The movement of prisoners around the prison remained too restrictive and negatively affected many elements of prisoners' daily life, including their attendance at activities and appointments. Over half the population were on 'keep apart' lists, where prisoners are not able to mix with others with whom they are in conflict, and leaders had lost oversight of the system (see paragraphs 2.5 and 6.5).
- 3.36 At the last inspection, we observed that prisoners were poorly accounted for. At this inspection, we found this had improved. During our roll checks, staff knew where prisoners were both in the units and away from them.
- 3.37 Drug use remained low, and, in the previous 12 months, 260 tests had been conducted, with just over 4% returning positive mostly for cannabis, which was lower than prisons that held a similar population, where the average was at 14%. The prison had a drug strategy, and a well-attended meeting took place. While most action was implemented in reasonable time, much still had yet to take place, for example, staff had not been briefed on what to look for when a prisoner was under the influence of substances.
- 3.38 During the inspection, seven prisoners were on closed visits (where the prisoner and visitor are prevented from having any form of physical

contact). While cases were reconsidered every month, reviews lacked detail and did not justify prisoners remaining on closed visits – in two cases, the prisoners had been on these restrictions for over seven months. We were also not confident that the prison sufficiently justified placing prisoners on closed visits, for example, a man who had failed a mandatory drug test had been placed on the restriction without any evidence of illicit articles having been supplied through visits.

Safeguarding

Expected outcomes: The prison provides a safe environment which reduces the risk of self-harm and suicide. Prisoners at risk of self-harm or suicide are identified and given appropriate care and support. All vulnerable adults are identified, protected from harm and neglect and receive effective care and support.

Suicide and self-harm prevention

- 3.39 There had been no self-inflicted deaths since our last inspection. The recorded rates of self-harm had declined by 16% since 2021, with 257 reported incidents involving 98 prisoners in the previous 12 months. This was similar to other comparable prisons. The use of constant supervision was low two prisoners had been placed on supervision over the same time frame.
- Only a minority of self-harm incidents were serious, but reviews were not conducted, and leaders could not identify lessons to be learned to further reduce the potential for prisoners to self-harm.
- 3.41 The safer custody team was small but effective. The team, and particularly the safety hub manager, provided good support and guidance to staff and had helped to improve prisoners' day-to-day experience.
- 3.42 Useful data were collated and analysed, providing leaders with valuable information on trends and the causes of self-harm, which was discussed at monthly safety meetings. The weekly safety intervention meeting (SIM) was effective, multidisciplinary, and well-attended, demonstrating that there was a good focus on prisoners of concern.
- 3.43 Involving families and carers in supporting prisoners during their stay at Brinsford continued to be a key component of prisoner care. The safety team, and other prison departments tried to involve families when prisoners were going through difficult times, such as bereavement, or when they used self-harm as a coping strategy. We observed some excellent examples of prison staff making special efforts to support prisoners.
- 3.44 The assessment, care in custody and teamwork (ACCT) case management process for prisoners at risk of suicide or self-harm was improving. Assessments were thorough and care plans reflected that prisoners' individual needs were considered. The standard was yet to

be consistent across the prison – daily summaries of interactions with prisoners were not always recorded and other sections of ACCT documentation were sometimes incomplete. Prisoners supported by ACCTs reported adequate levels of day-to-day care and support. A tiered quality assurance process was in place, which demonstrated a commitment to improve the care offered.

3.45 Prisoners did not have good access to Listeners. They were not available during key moments of prisoners' time at Brinsford, such as during their arrival (see paragraph 3.10), and there were too few of them for the population, which was exacerbated by all of them being assigned to the same unit. Listeners did not feel unit staff supported them and we were given many examples where prisoners in crisis had requested a Listener, but one had not been provided, or where staff brought Listener sessions to an abrupt end.

Protection of adults at risk (see Glossary)

- 3.46 Adult safeguarding arrangements were not yet fully embedded. A local safeguarding strategy provided comprehensive guidance on how to support a prisoner at risk of abuse and neglect, including information about the contact details of local safeguarding boards for adults and children. However, it had yet to be published and most staff had not had any specific training to improve their understanding of how to identify vulnerable prisoners and were unaware of formal safeguarding protocols.
- 3.47 Structures were in place, however, to discuss at risk prisoners' cases internally, such as the daily safety meeting and the SIM. The safety hub manager had also introduced a weekly safeguarding meeting, an informal drop-in session for anyone to raise safeguarding referrals or discuss prisoners of concern.
- 3.48 There were no links with the local safeguarding adults boards, and no evidence that expert advice had been sought when offering training, writing policies or providing general advice on how to manage prisoners with complex needs.

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 During our visit, many prisoners told us staff were polite and helpful. We saw some informal and friendly interactions, and humour was used appropriately. In our survey, 69% of prisoners said staff treated them with respect, while 66% said they had a member of staff they could turn to if they had a problem, which was similar to other prisons. We saw less evidence of widespread low-level rule breaking this time compared to the last inspection.
- 4.2 Nevertheless, prisoners described a small number of staff as less helpful, dismissive and sometimes condescending. They were more apparent in some units than others.
- 4.3 Compared to other prisons, Brinsford had few officer vacancies and attrition rates were low. Staff supervision was still limited and made more difficult by the layout of the units, which limited lines of sight. Staff continued to congregate in offices outside the wings, which meant there was inadequate supervision of prisoners, particularly in a jail with high levels of violence. This was disappointing because it was an issue we had highlighted in our 2021 inspection. In addition, regime pressure left staff with limited time to speak to prisoners. While we saw some good interactions, many were hasty and offhand.
- 4.4 Not enough key work sessions (see Glossary) were being delivered despite this being prioritised by leaders, although there was some early evidence of improvement. Those sessions we reviewed were inconsistent. Most did not address sentence progression or set meaningful targets. There were some examples of officers who provided sensible and practical help to their prisoners, but they were rare. (See also paragraph 6.10.)
- 4.5 The use of peer workers was underdeveloped, many were not being used to their full potential and too few prisoners were aware of their roles. Some were more embedded than others, such as conflict coaches (see paragraph 3.15), while peer supporters, such as Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) or those from the Shannon Trust did not receive sufficient support to do their jobs. (See paragraphs 3.45 and 5.8.)

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 at Brinsford were bleak and leaders had not set high enough standards. For example, the internal prison environment was tatty and uninspiring, and many communal areas had been neglected, with peeling paint and accumulated dirt. There were few creative or engaging displays, and most walls and noticeboards were left bare or contained outdated information.
- 4.7 Likewise, most residential units were drab and several unused empty side rooms were messy. Where association equipment, such as table tennis and pool tables, was available, it was well used, and provision was better in residential units 5 and 6.



Side room

4.8 Most cells were austere – too many were covered in toothpaste and had limited furniture. Those in double cells did not have lockable cupboards. Cells that had benefited from the Clean, Rehabilitative, Enabling and Decent programme, a redecoration initiative involving a party of prisoners and professional painters, were better. Most toilets were stained beyond repair and indecent, some double cells were very

cramped and lacked privacy curtains. Leaders had put in place assurance checks to uphold standards, but they had not yet led to a sufficient improvement in cell conditions.



Stained toilet



A cramped cell



Toothpaste on the walls of a cell

- 4.9 Showers were poorly ventilated and mouldy, although a programme of refurbishment was underway. Those that had been renovated were in good condition. Despite staff's concerns about safety, cleaners were poorly supervised, which meant items, such as razors, were often left on shower floors. During association, prisoners could not use landing showers, which left only a small number of facilities available.
- 4.10 In our survey, prisoners were significantly more negative than their counterparts in other similar prisons about access to basic items, for example only 52% of prisoners said they had enough clean, suitable clothes for the week, compared to 76% in similar prisons, and only 35% said they had clean sheets every week, which was also lower than elsewhere (63%). Both staff and prisoners complained about perpetual shortages of clean bedding and towels, and while the problem had been addressed following the announcement of our inspection, it was a huge source of frustration and not decent.
- 4.11 Prisoners in residential unit 5 had in-cell showers and more spacious cells. The environment was much more pleasant and there was a large outdoor exercise area, including a tennis court, all of which motivated prisoners to behave well so they could continue to access these facilities.



Tennis court on unit 5

- 4.12 Exercise yards for the other residential units had some gym equipment.

 Despite the large grounds, yards were relatively small and basic compared with the outside area available to those in residential unit 5.
- 4.13 During the inspection, we found cell call bells were not being answered. This was reflected in our survey where only 21% of prisoners said they were answered within five minutes, which was lower than in similar prisons (39%).

Residential services

- 4.14 Prisoners we spoke to were very positive about the food, many valued the option of two hot meals a day. The catering team made a substantial amount of the food in house, which supported both value for money and nutritional content.
- 4.15 Despite this, only 42% in our survey said they had enough to eat at mealtimes which was lower than elsewhere (65%). This was partly attributable to portion control, which was not being sufficiently well supervised. Oversight of the meal service was not good enough. During our inspection, we saw the food running out during one meal. Breakfast was meagre, but often prisoners did not even receive it, as staff did not hand out packs consistently. Leaders had tangible plans to supplement the breakfast packs shortly after our inspection.
- 4.16 During the inspection we observed several situations where utensils for halal or vegetarian food were used for the wrong type of foods, which was a further cause for concern.

- 4.17 Too few prisoners could eat together. Except for residential units 5 and 6, prisoners were unlocked simply to collect their meals but had to eat them in their cells, often in cramped conditions next to a stained toilet.
- 4.18 The shop was limited, and prisoners complained about a lack of fresh ingredients available, as leaders had failed to provide suitable storage facilities to store these items. There were no self-catering facilities for most prisoners, compounding prisoners' experiences of not having enough to eat. Residential units 5 and 6 benefited from some limited self-catering equipment, such as microwaves and air fryers, but prisoners could not use them as much as they would have liked given the limited range of items on the shop list.
- 4.19 Prisoners could only buy items from two catalogues and told us they often waited six to seven weeks for their orders. Nevertheless, 61% of prisoners in our survey said the shop sold what they needed, more than in similar prisons (47%).
- 4.20 Prisoners from black and minority ethnic backgrounds told us they found some of the toiletries particularly expensive and others would have preferred to have been able to buy a more diverse range of spices. (See paragraph 4.29.)

Prisoner consultation, applications and redress

- 4.21 Leaders were keen to consult prisoners about prison life, but consultation was not always organised effectively. In our survey, only 44% of prisoners, fewer than at similar establishments (67%), said they were consulted about everyday issues. Prisoner representatives from most units attended monthly council meetings, which allowed them to raise issues with a governor. Despite this, very few prisoners we spoke to were aware of the council or its role and did not know who their unit representatives were. Outcomes from council meetings were not communicated well to prisoners.
- 4.22 Prisoners' very limited time out of cell made it difficult for them to resolve day-to-day issues or make requests informally by speaking to staff. Men remained frustrated by the paper-based formal applications system. Applications were not tracked so leaders could not make sure prisoners were receiving timely or appropriate responses.
- 4.23 Prisoners' complaints were logged and tracked, and a good range of data relating to complaints was analysed to monitor and identify disproportionate outcomes for minority groups. However, in our survey only 15% of prisoners said their complaints had been answered within seven days, fewer than at our last inspection (38%). The prison's own data showed that only about two-thirds of complaints were answered on time. Paperwork we reviewed showed that responses to complaints were generally polite and addressed the issues raised.
- 4.24 In our survey, only 34% said it was easy to communicate with their legal representatives, but, during the inspection, we did not see any evidence that this was due to any restrictions from within the prison.

Prisoners could use in-cell phones to contact their legal representatives and those who most needed to (for example those facing deportation or who were on remand) said they did so easily and as often as they needed. Legal visits and video links were also available and well-used.

4.25 Legal support was otherwise restricted. There was no legal services officer, the legal texts in the library were many years out of date, and prisoner peer workers did not have information on sources of legal support to give out.

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.

- 4.26 Our survey indicated few significant differences in the perceptions of those with protected characteristics compared with other prisoners, although there were some notable exceptions. For example, black and minority ethnic prisoners felt their visitors were treated with less respect than those of their white counterparts (24% compared with 49%) and they also found it more difficult to make an application (33% compared with 59%), while 41% of younger prisoners said they had been restrained compared with 18% of others.
- 4.27 Since the last inspection, leaders had taken some steps to improve their understanding of prisoners' experiences and needs, for example through consultation and the use of data (see paragraphs 4.31 and 4.32). Despite this, follow-up action planning was ineffective, and it was not clear what improvements were going to be made to address the weaknesses they had identified. This was further undermined by poor support for prisoners with some protected characteristics.
- 4.28 Brinsford's population was young, and more than half (58%) were aged between 18 and 20. The under 21-year-olds we spoke to told us they were bored and had little to do the work on offer did not interest them and they were often reluctant to do it because they perceived they were paid less than over 21-year-olds. There was also little to keep them occupied while they were on association. Leaders told us they did not differentiate between the younger adults and those aged between 21 and 28, and there was little specialist provision. However, remand prisoners (93% of whom were under 21) had recently been prioritised for key work sessions as it was recognised there was a gap in support for this group. However, key workers were yet to receive any form of specialist training on working with young people and the overall quality of key work was inconsistent. (See paragraph 4.4.)

- 4.29 The population was ethnically diverse, with 21% identifying as black or black British and 13% as Asian or Asian British. Black prisoners told us the shop did not offer a wide enough range of affordable skincare or haircare products for their needs (see paragraph 4.20). There was limited targeted provision was available for these groups beyond a handful of small-scale events, such as for Black History Month, led by the chaplaincy.
- 4.30 Foreign nationals comprised 13% of the population and were better supported than at our previous inspection. They were helped by a dedicated officer based in the offender management unit and were able to speak to Home Office representatives about their individual cases. Those held under immigration powers also received further support from a charity. However, there was very limited use of telephone interpretation and translated material available to help the minority of foreign nationals who did not speak English participate fully in prison life.
- 4.31 Leaders were making better use of data to determine disproportionate outcomes. For example, they identified that black and minority ethnic prisoners were more likely to have force used against them than other prisoners, and subsequently held focus groups with those affected. Nevertheless, it was not clear what the outcome was or whether any action was identified to address concerns.
- 4.32 Consultation arrangements were in place, with the expectation that senior leaders would hold a quarterly forum with those with protected characteristics for whom they were responsible. They would also produce a monthly report summarising their work and plans for developing their area. Despite oversight from senior leaders, too many forums were sporadic, and when they were held, they rarely discussed issues in sufficient depth or generated meaningful action to bring about change. This meant leaders were not well enough informed of the experiences or needs of those with protected characteristics.
- 4.33 Complaints about discrimination were taken seriously and investigated thoroughly, and an external organisation had recently started quality assuring responses. There had been just 12 complaints in the previous year. A survey had been sent to all prisoners to assess their levels of awareness of the discrimination complaints process, which was positive, although responses were yet to be collated.
- 4.34 There were equality peer workers on most wings, and those we spoke to were enthusiastic, but they were under-used (see paragraph 4.5). The minutes of monthly meetings did not record their input and they were not visible in the residential units or known to their peers. Their work was hindered by their inability to leave their units to meet those with protected characteristics they represented. When forums led by senior managers did take place, peer workers were not always fully involved, which meant prisoners were not encouraged to participate in prison life to support fair treatment.

- 4.35 Leaders had welcomed external scrutiny and support for equality work. They had recruited two external, non-executive members of the senior leadership team shortly before the inspection. Both were young black men and one had been in prison. Although it was too early to assess the impact on outcomes, this initiative aimed to help leaders better understand the experiences and perspectives of prisoners from black and minority ethnic backgrounds. (See paragraphs 1.8 and 2.9.)
- 4.36 The HM Prison and Probation Service regional lead for equality visited the prison every quarter to review processes and highlight areas of strength and weakness. An external organisation carried out a comprehensive needs analysis and made specific recommendations to improve the quality of consultation, data analysis, and leadership oversight. While leaders had taken some steps to improve these areas, many of the identified weaknesses had not been addressed in full, a year after the recommendations had been made.

Faith and religion

- 4.37 Access to corporate worship had improved significantly since the last inspection. In our survey, 73% said they could attend religious services every week if they wanted to, compared with 45% last time.
- 4.38 The chaplaincy was well-resourced and well-integrated into all areas of prison life and provided prisoners with very good pastoral care. The team hosted several events and forums where prisoners and staff could raise awareness of the different faiths represented in the prison. They also aimed to improve prisoners' experiences, for example bringing together kitchen staff and Muslim prisoners to make sure their dietary needs were met during Ramadan. However, there were several examples during the inspection where poor supervision led to utensils for halal food being used incorrectly (see paragraph 4.16).



The chapel

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.

4.39 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

- 4.40 Partnership working was characterised by good working relationships between health service providers and the prison team, but the partnership had failed to address ongoing problems with making sure patients got to their health care appointments. This was reflected in our survey where prisoners were more negative about access to health care services than previously and compared with those from similar prisons. Some patients told us their experiences were associated with the poor regime.
- 4.41 In our survey, prisoners were negative about the standard of health care across a range of areas compared with those in other similar prisons. However, we found that clinical governance arrangements were effective and focused on delivery and improvements in patient

- care. There were scheduled audits and lessons learned from incidents were disseminated effectively among staff.
- 4.42 Clinical leadership was strong at all levels and frontline staff said they felt well supported. There was strong joint working between primary care staff and those working in mental health and substance misuse, and they were operating as one health care team. Despite vacancies in primary care, mental health, substance misuse, the pharmacy and administration, staff continued to deliver a good range of services.
- 4.43 Staff training met the required standard and supervision arrangements and access to professional development for all staff were good.
- 4.44 We observed staff who knew their patients and treated them with kindness, dignity, and respect. Health care staff used electronic clinical records and those we reviewed fulfilled the expected requirements, described patients' needs well, and an appropriate plan of care was outlined.
- 4.45 There were sufficient treatment rooms, but some did not comply with infection prevention standards. For example, the torn flooring needed to be replaced the renovation had been added to the schedule of work to be undertaken.
- 4.46 Emergency resuscitation equipment was in good condition and daily equipment checks were completed. Health care practitioners were trained to provide immediate life support, were available 24 hours a day and we were told an ambulance was called promptly in an emergency.

Promoting health and well-being

- 4.47 There was no prison-wide strategy to provide a cohesive approach to health promotion. A national calendar for promoting health was followed and, when appropriate, other prison departments were involved in joint campaigns.
- 4.48 There were vacancies for health champions in many units. Two health champions said they found their training of great value and enjoyed their role in promoting health. They were well supported by an enthusiastic patient engagement lead staff member, who led the health promotion initiatives.
- 4.49 Information about health services was displayed routinely and a monthly newsletter was produced for patients, with key updates. Information boards displayed an array of posters, but they were not accessible to those with lower levels of literacy.
- 4.50 A range of age-appropriate health screenings and vaccinations was offered routinely, and prisoners had access to sexual health support and barrier protection. The health care team had actively promoted vaccinations to the prisons' younger population and seen improved uptake.

Primary care and inpatient services

- 4.51 The primary care service was well led and had good managerial support. It operated a seven-day, 24-hour nursing service, with GP clinics delivered three times a week. An out-of-hours service was available to support patients and practitioners.
- 4.52 The primary care team was underpinned by a stable staff group, who were motivated to provide safe and effective care. Patients were offered an appropriate range of primary care services, and all health care applications were triaged by a nurse. Urgent slots with the GP were available should a patient have needed to be seen promptly. Waiting lists for allied health professionals did not exceed the accepted standard and patients could get a GP appointment within seven days.
- 4.53 Reception and prompt secondary health screenings for new patients were thorough and referrals to other services were made during the first screening, which meant patients' needs were identified early. Long-term conditions were well managed, and patients had annual reviews. Care plans for those with a long-term condition were in place, but patients were not involved to make sure they were tailored to their individual needs.
- 4.54 The team had a good mix of skills and there were daily handover meetings, where staff shared relevant information about patients. In addition, multidisciplinary meetings were held every week to discuss those with complex needs.
- 4.55 Hospital appointments were monitored effectively, and although small in number, some had been cancelled, either by the hospital or health care staff, and then rearranged, which meant there was a further delay. Patients were not routinely informed about the delays, which inspectors raised with the head of health care while we were on site, and we were confident this would be addressed.
- 4.56 The inpatient facilities were spartan, but some redecoration was underway and was being carried out by trusted prisoners. The unit was a regional facility for patients aged under 25. Admissions had to meet the clinical criteria of the unit and regular referral meetings were conducted to review all applications. During the inspection, the unit was being used primarily for patients with mental health problems who were waiting for a transfer to hospital under the Mental Health Act.
- 4.57 At the last inspection, patients' time out of cell was limited and there was no programme of therapeutic activity. This time we found there had been no improvement in the regime. We saw officers being regularly redeployed to other parts of the prison, which meant patients spent too long in their cells. Most time out of cell was taken up with basic tasks, such as showering and collecting meals, but some patients enjoyed using the gaming console. They had access to the outside area, but only when staffing allowed.

- 4.58 We saw evidence of patients in the unit having health care assessments and care plans, along with regular input from specialist clinicians, but no care planning information was shared formally with prison staff.
- 4.59 A regular discharge clinic prepared patients for release and made sure they had sufficient information so they could register with a GP. (See also paragraph 4.90.)

Social care

- 4.60 There was a memorandum of understanding between HMP/YOI Brinsford, the health care provider and Staffordshire County Council. No patients were receiving a social care package (see Glossary).
- 4.61 The prison's governance and oversight of the referral process was weak, and many staff did not know whom to contact if they considered that a patient needed support. The deputy head of health care was addressing this and liaising with the prison to devise a pathway to guide staff and raise awareness.
- 4.62 Patients were screened by health care staff on arrival to identify their needs. Only one referral had been made to the local authority in the previous 12 months, but it did not meet the threshold for care. There was no information advising patients how to refer themselves, which was poor.
- 4.63 The prison did not have a formal buddy system (in which prisoners support other prisoners) for patients who might have required some additional assistance, such as with collecting meals.
- 4.64 Equipment and living aids were available from the local authority and personal alarms could be provided to help patients summon assistance in an emergency.

Mental health care

- 4.65 Integrated mental health and psychosocial substance misuse support was available for patients. The small mental health team comprised of mental health nurses and a support worker and operated Monday to Friday, 9am to 5pm, with emergency duty cover at weekends. Following some recent staffing challenges, the team was now meeting the demand. Vacancies persisted for the psychologist and assistant psychologist positions, despite efforts to attract candidates, and there was a lack of counselling provision.
- 4.66 Referrals were received mainly from health care staff in reception, but also from prison staff, and patients could refer themselves. The referrals were triaged daily, and assessments carried out within the required timescales, based on urgency. Staff undertook outreach in the residential units but were sometimes unable to see patients because of activity scheduling issues.

- 4.67 The duty worker attended assessment, care in custody and teamwork reviews for those at risk of suicide or self-harm, and the team worked well with prison colleagues to support vulnerable prisoners. A stepped care model was used and most patients received support for mild to moderate needs, such as anxiety and depression. Five patients with more severe and enduring needs received appropriate support under the care programme approach.
- 4.68 Groups were available to address various issues, such as anxiety and depression, although attendance had proved challenging because of prison regime problems and a reluctance among some patients to get involved. One-to-one sessions were available for those who chose not to take part in group work.
- 4.69 Access to appointments with the psychiatrist was prompt and they saw patients with more complex needs and those requiring medicines, such as anti-psychotics. Routine appointments were available within a few weeks and urgent appointments within a week or two. The shared care pathway with the health care provider made sure that patients who required physical health checks because of the medicines they were prescribed, received them in a timely way.
- 4.70 Staff created detailed and person-centred care plans with the involvement of patients. In-depth records were made after each appointment, identifying what care and support had been provided. Staff generally saw patients at the frequency stated in their care plans, although access issues sometimes meant appointments were delayed.
- 4.71 Prison officers had not received mental health training due to the prison's focus on other training priorities. Inclusion had offered training to the prison. Support for prisoners with a neurodiversity presentation was being developed in partnership with the prison's neurodiversity lead staff member.
- 4.72 In the 12 months before the inspection, five patients had been transferred to mental health hospitals, but only one within the 28-day timescale. The longest wait was 92 days, which was unacceptable. A further two patients were awaiting a transfer.

Substance misuse treatment

- 4.73 Clinical needs were low, and four patients were receiving opiate substitution treatment (OST) medication. Fifty-two patients were receiving support from the psychosocial team. We observed caring and skilled staff and positive interactions with patients.
- 4.74 A drug strategy was in place and there were regular meetings and good partnership working between the services' staff and prison.
- 4.75 Patients were assessed on arrival and care was delivered depending on needs, and a non-medical prescriber (NMP) from HMP Featherstone provided flexible prescribing. Few contingencies were in

- place in case the NMP was absent, but regional prescribers were available to support the service.
- 4.76 Regular reviews of care were carried out jointly with a member of the psychosocial team. Both teams worked well together and demonstrated a good understanding of patients' needs and how to support them.
- 4.77 A pathway of care was in place for patients found to be under the influence (UTI) of illicit substances. However, prison staff did not receive substance misuse training and not all those suspected of being UTI were reported to the health care team, which was poor and posed a risk.
- 4.78 The psychosocial team provided a good range of targeted support based on risks and individual goals. The Inclusion team included substance misuse service and mental health staff, resulting in a service that jointly met the needs of patients well. Care plans were personalised and detailed.
- 4.79 One-to-one psychosocial work was delivered, and service user feedback collected to help inform service delivery. There was no dedicated recovery wing, but support was provided in the residential units. A newly opened incentivised substance-free living unit had recently opened. It aimed to provide a safe and calm environment for those wanting to remain abstinent while in custody.
- 4.80 A range of groups was available, but regime issues resulted in low attendance, undermining patients' recovery. External mutual aid groups were not available at the prison and there were no peer workers to direct patients to the service.
- 4.81 Joint working with prison and community services supported patients on release and naloxone (a drug to prevent an opiate overdose) was available.

Medicines optimisation and pharmacy services

- 4.82 Medicines were supplied by the pharmacy at nearby HMP Oakwood. A full-time pharmacy health care assistant (HCA) had a good understanding of patients' medication and received effective management support.
- 4.83 Most patients' queries about their medication were managed by health care staff. However, arrangements could be made for patients to telephone the pharmacist at HMP Oakwood for advice. Pharmacy staff worked with health care and prison colleagues to help patients who needed support with taking their medication. This had included supporting a patient with autism to manage his own medication safely and keep it in his possession (see paragraph 1.9).
- 4.84 Oversight and governance were effective an established safer prescribing group reviewed prescribing practice and a medicines management meeting reviewed trends, effectiveness and incidents.

- 4.85 Prescribing and administration of medicines were documented on the electronic clinical records system. The number of patients with all or some of their medication in possession (IP) was low. IP reviews were undertaken to make sure there was an update every six months. Patients did not have access to lockable storage facilities in their cells, which meant IP medication could not always be safely stored.
- 4.86 Out-of-hours provision was available for medicines, such as antibiotics, which were kept in a dedicated cupboard. Policies enabled patients to receive some medicines without a prescription.
- 4.87 Medicines were stored appropriately in the treatment rooms visited. Fridge and room temperatures were checked and recorded every day. Controlled drugs were appropriately managed and suitable arrangements were made for transporting medication around the prison.
- 4.88 Medicines administration took place at 8am, which supported patients with work commitments. The later administration time of 4pm was not appropriate for some medication, such as night sedation, and meant that patients experienced sedating effects too early, which did not meet national guidance.
- 4.89 We observed safe and effective medicines administration led by nurses, and patients were routinely asked for their ID before their medication was supplied. Prison officers' supervision at the hatch made sure there was a suitable level of confidentiality.
- 4.90 Adequate measures were taken to make sure patients had enough medication when attending court or being released. If necessary, an FP10, a prescription that could be taken to a community pharmacy, was provided.

Dental services and oral health

- 4.91 A full range of dental services was available to all prisoners regardless of category or sentence length. Three sessions were available each week and waiting times were short for routine appointments at about three weeks. Follow-up appointments for treatment were available in about seven weeks. Urgent appointments could be arranged for the same day or next available session when patients had dental pain.
- 4.92 The dental nurse triaged applications and scheduled appointments based on need. Oral health advice was provided to patients when they attended their appointment and items, such as floss and interdental picks, were available to buy from the prison shop.
- 4.93 The dental suite was clean, equipment was serviced every year and repairs were carried out as needed. There was a separate decontamination room, which was well organised. The dental chair and flooring needed to be replaced, which the dental team had escalated with the prison. However, this situation had remained unresolved since the previous inspection.

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 Time out of cell remained poor for too many prisoners. In our roll checks, nearly a third of prisoners were locked up during the core day while only 40% took part in purposeful activity, far too few for this type of establishment and its young population.
- 5.2 Time out of cell for the one-fifth of prisoners who were unemployed and for the many who refused to attend their allocated activities each day was poor. It should have been 90 minutes, but many prisoners told us they often received about one hour a day in addition to the time it took to collect their meals.
- Those in employment spent between four and eight hours out of their cell, and many full-time workers had association, gym or library sessions on at least two evenings a week to make up for sessions they missed because they were working. Full-time workers could go to the Acorn Centre for evening association one day a week it provided much better recreation facilities than was available in the units (see paragraph 3.16).
- There were only enough full-time activity spaces for one-third of the population, and during the inspection not all of these placed were filled, so only about one quarter were in full-time purposeful activity. (See paragraphs 5.12 and 5.13.)
- 5.5 The 90-minute association period allocated was too short and a significant cause of frustration. During this time, prisoners needed to have a shower, socialise with their peers, spend time outside and clean their cells. In our survey, only 22% of prisoners said they had enough time to carry out domestic tasks on more than five days a week, which was lower than last time (45%) and compared with similar prisons (43%). Leaders understood this was a priority area that required addressing and there were credible plans to increase this period to three hours.
- 5.6 The library was good, but access remained far too limited for most prisoners. Prisoners were timetabled to attend once a fortnight depending on their residential unit, but there was capacity for only 15 prisoners at a time. Some of these sessions had been cancelled

recently as there was not enough staff to escort prisoners to the library. Prisoners working in industries also had weekly timetabled sessions during the working day, which prompted prisoners to use the library when they perhaps would not otherwise have done so. Although a delivery service was available to supplement the lack of access, prisoners were not aware of it and staff did not promote it widely enough. This was reflected in our survey, where only 8% said they could have books delivered, compared with 58% at other similar prisons and 19% last time.

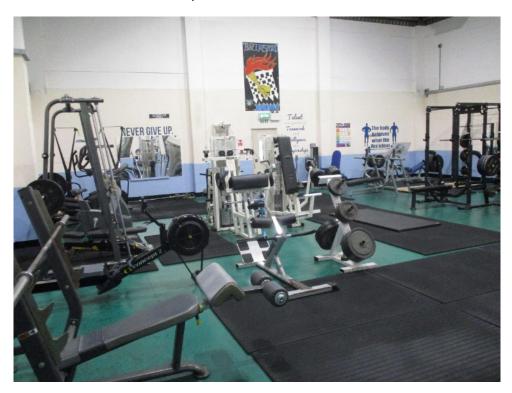
5.7 The library was pleasant and welcoming. Prisoners were positive about the staff and particularly appreciated being able to borrow video games. There was a good range of books, magazines, and newspapers suitable for readers of all levels, and some thoughtful themed displays, for example for Gypsy, Roma, Traveller History Month. Free books were available to give out to children on social visits, and prisoners could record books for their children or younger family members as part of the Storybook Dads project. There were not enough books available in languages other than English.



The library

5.8 The prison's reading strategy was not well embedded (see paragraph 5.23) and the library was not yet sufficiently well-integrated into the strategy to support emergent readers. The Shannon Trust mentoring scheme to promote prisoners' reading skills was operating in the prison but did not make good use of the library, perhaps due to the issues with access. Additionally, seven of the nine trained mentors were in the same residential unit, and could not access other units to mentor other prisoners, undermining the scheme's effectiveness.

- 5.9 Access to PE was good and almost all prisoners could use the gym at least once a week. Prisoners on the enhanced level of the incentives scheme could attend up to three times a week.
- 5.10 PE facilities were good, and included a sports hall, outdoor sports pitch and a climbing wall, as well as cardiovascular and weights equipment in the gym. Prisoners could undertake qualifications in gym instruction or gain a Duke of Edinburgh award. There were some links with external organisations, for example, a football team comprised of prisoners played against external teams in a Sunday league. The prison had recently developed links with Wolverhampton Wanderers as part of the Football Association Twinning programmes, which aim to improve prisoners' mental and physical health and well-being and enable them to obtain a qualification.



The gym

Education, skills and work activities



This part of the report is written by Ofsted inspectors using Ofsted's inspection framework, available at https://www.gov.uk/government/publications/education-inspection-framework.

Ofsted inspects the provision of education, skills and work in custodial establishments using the same inspection framework and methodology it applies to further education and skills provision in the wider community. This covers four areas: quality of education, behaviour and attitudes, personal development and leadership and management. The findings are presented in the order of the learner journey in the establishment. Together with the areas of concern, provided in the summary section of this report, this constitutes Ofsted's assessment of what the establishment does well and what it needs to do better.

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

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Inadequate

Personal development: Requires improvement

Leadership and management: Inadequate

- 5.12 Leaders and managers did not provide enough full-time education, skills or work activity spaces for prisoners. Only one-third of prisoners could access a full-time activity place at any one time, which was not enough. In particular, there were too few spaces for prisoners to study mathematics and English. A small but significant number of prisoners was unemployed.
- 5.13 The nature of the prison regime, which leaders had split into two parts, meant that not all prisoners could access all vacancies in education, skills or work. As a result, despite the shortfall in full-time activity spaces, too many were unfilled. Leaders rightly recognised this issue and had devised plans for a new regime so that all prisoners would be able to attend all activities.
- 5.14 The way in which leaders and managers allocated prisoners to activities was hasty and ill thought out. For example, a significant minority of prisoners started work activities without having completed an induction to education, skills or work. Prisoners with very low levels

of mathematical and/or English ability often did not study these subjects. Staff who managed the allocations process did not routinely have sufficient information about prisoners' starting points. They were not able consistently to allocate prisoners to the education courses they most needed to undertake.

- 5.15 Leaders and managers offered a curriculum that included a variety of subjects relating to prisoners' personal and social development needs, as well as their career goals. Prisoners could study accredited vocational courses in hospitality, construction, traffic management and sports coaching.
- 5.16 However, there were no opportunities to work towards useful qualifications in work areas, such as waste management and horticulture. The curriculum was also not challenging enough for prisoners with higher-level starting points, or for those who progressed successfully through their initial levels of study in vocational areas.
- 5.17 Staff who led induction sessions planned them well. They provided prisoners with information that was objective and realistic about their options while at the prison. However, because prisoners often arrived late to induction, or did not arrive at all, they did not consistently complete the full array of induction activities.
- 5.18 Leaders did not make sure that there was consistently high-quality careers information, advice and guidance (CIAG) for all prisoners. CIAG staff worked diligently with prisoners, particularly at the start of their time at the establishment. Prisoners also found frequent on-wing interactions with education staff useful in helping them to plan their career pathways. However, there were not enough CIAG staff to review prisoners' career goals frequently.
- 5.19 Support for prisoners close to release was good. CIAG staff arranged pre-release support courses, and prison managers had developed fruitful links with local employers to enable prisoners to prepare for external work opportunities. The number of prisoners who had got a job or started an apprenticeship after leaving the prison had increased significantly.
- 5.20 There were very limited opportunities for prisoners to undertake external work opportunities while still in custody via release on temporary licence (ROTL). However, the very small number of recent ROTL placements had been successful.
- 5.21 The pay policy encouraged prisoners to participate in education and vocational training. The pay rates for studying English and mathematics, for example, were considerably higher than for activities such as work.
- Novus provided education courses and vocational training. Although teachers and instructors had relevant expertise, the quality of the courses they taught was often too low. Teachers and instructors did not plan the content of their curriculums carefully enough. They focused on

the requirements of awarding organisations, rather than considering the knowledge, skills and attitudes that prisoners most needed. They did not use the results of assessments – such as initial and diagnostic assessments – to teach topics that met prisoners' needs well. As a result, many did not gain substantial new knowledge during their courses.

- Prison leaders were still in the early stages of implementing the prison reading strategy. It had not, at the time of the inspection, benefited the great majority of prisoners who had low-level reading skills. Only a few of them had received a reading-specific assessment. Staff, including English teachers, had received only limited training on the use of phonics to teach reading. They did not use phonics to support prisoners with limited reading ability, such as those in foundation English classes.
- In too many cases, teachers and instructors did not use teaching activities well to support prisoners to develop their knowledge, skills and attitude. For example, in English for Speakers of Other Languages classes, teachers did not help prisoners to practise their pronunciation skills, and in business classes they did not provide prisoners with enough time to work through the problem-solving activities they had been set.
- 5.25 In better classes, teachers and instructors checked prisoners' knowledge well. They provided prisoners with helpful guidance on how to improve the standard of their work. This helped prisoners to remember the topics they had learned. However, teachers often did not sufficiently assess prisoners' work. Consequently, prisoners struggled to recall the topics they had previously learned.
- 5.26 Prisoners did not benefit from peer mentors' support in the large majority of education classes or vocational training workshops. Prison restrictions meant mentors too often could not work with the prisoners they most needed to support. Although a substantial number of peer mentors had completed useful training, leaders and managers had deployed only a very small number of them to classroom and workshop support roles. On the hospitality and catering course, mentors worked well to support their peers.
- 5.27 During most work activities, including wing work, the prisoners that attended worked diligently. They gained new knowledge and skills, but they were too often not aware of this. This was because instructors did not review prisoners' progress or opportunities for further development in their workplaces effectively enough.
- Instructors and trainers did not effectively support the development of prisoners' mathematics or English knowledge. They did not consider, for example, the mathematics and English that prisoners needed to complete their vocational training or work activities to high levels. Most instructors and trainers did not know prisoners' English and mathematics abilities.

- 5.29 Across the entire prison, there was insufficient support for prisoners with learning difficulties and/or disabilities (LDD). Leaders and managers were aware of the very high levels of LDD need at the prison, and they had been successful in making sure that prisoners in education and vocational training classes received useful in-class support. However, there was little support available for prisoners in work roles. Leaders had not made sure that enough prison staff had access to information about prisoners' LDD needs.
- 5.30 Too many prisoners left their courses before they could take their final assessments. Approximately 20% of prisoners left their courses early, but rates were significantly higher on courses such as traffic management, and English and mathematics at levels 1 and 2. As a result, overall rates of achievement on courses were too low, although the large majority of prisoners who completed their courses passed their final examinations.
- 5.31 The standard of written work that most prisoners produced was not good enough. Prisoners too often produced limited responses to written tasks, and work was presented poorly. Those who studied vocational subjects such as construction, and hospitality and catering, produced a high standard of practical work. They demonstrated good knowledge of topics, such as food safety and food preparation in hospitality, and tiling and carpentry in construction.
- Too few prisoners had positive attitudes towards education and work. Their attendance rates at education, skills and work were too low, and had not improved over time. On education courses, for example, approximately half of the allocated prisoners were frequently absent from classes. Attendance rates were higher on vocational training courses such as construction.
- 5.33 Education and training activities often started late because prison staff did not conduct movement to activities swiftly enough. In the worst cases, prisoners arrived approximately 30 minutes late to their classes.
- 5.34 The standard of prisoners' behaviour was not high enough. A significant minority behaved poorly in lessons. Teachers and instructors challenged this, but prisoners did not modify their behaviour sufficiently well.
- 5.35 A significant minority of prisoners reported that they did not feel safe during education and training activities.
- 5.36 On education and vocational training courses, teachers and trainers focused on developing prisoners' knowledge of fundamental values, tolerance and equality and diversity. Such topics enabled prisoners to, for example, contrast their own cultural experiences with the treatment of Gypsy, Traveller and Roma people. Education managers rightly acknowledged that a few teachers lacked the confidence to tackle some of the issues raised when developing prisoners' attitudes and values.

- 5.37 Leaders and managers linked the successful careers support for prisoners at the end of their sentences with helpful job search activities conducted via internal prison partners. However, prisoners were not able to use the virtual campus (prisoner access to community education, training and employment opportunities via the internet) to access a more comprehensive range of job opportunities. In other areas of the prison, such as in education, staff used the virtual campus in a limited but productive way.
- 5.38 Leaders and managers used forums such as the quality improvement group to accurately identify the key areas in which they needed to make progress. However, they did not use these meetings or documents such as quality improvement plans to set or measure targets that would help staff to make the necessary changes.

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.

- There was a clear focus on helping prisoners to maintain family ties, and we saw many instances of staff encouraging families to become involved in prisoners' lives. This included inviting family members, and care workers to help support prisoners in crisis (see paragraph 3.43). Notes from key work sessions (see Glossary) we reviewed also indicated that prisoners were often encouraged to maintain family ties. Family members were invited to celebratory events, such as the review after a prisoner had completed an accredited offending behaviour programme.
- Many prisoners had benefited from family interventions from resettlement partners, the majority had completed non-accredited workbooks, and a small number had undertaken accredited parenting courses. A number had received individual support from a Prison Advice and Care Trust (PACT) family engagement worker, who also helped prisoners who were not receiving social visits to identify and reconnect with family and friends they had lost contact with.
- In our survey, only 37% said they been able to receive a social visit more than once in the previous month, although this was far higher than in similar prisons we have inspected recently (24%) and compared to the last inspection (9%). The number of extra social visits a prisoner could attend depended on their level on the incentives framework. The prison offered 125 visiting sessions a week, but data indicated that, in the previous six months, only just over 80% of sessions were filled.
- 6.4 Many visitors said they had experienced delays of many hours when booking visits using the phone line, but they preferred this method to the online booking system as they received immediate confirmation when booking by phone. A small number of visitors said they had been turned away on arrival at the prison due to a mistake after using the online booking system. The prison did not systematically record or analyse data on how often or why visitors had been turned away. Although PACT, the family service provider, had carried out a survey of visitors earlier in 2023, the results had not yet been analysed, and the

prison had not carried out any recent analysis of prisoners' views to determine how to improve the visits experience.



Visits hall

6.5 The visits hall was comfortable and pleasantly decorated, and we saw positive interactions between staff, prisoners and their visitors. Many visitors and prisoners told us that visits often started late because of regime restrictions and 'keep apart' lists, where prisoners are not able to mix with others with whom they are in conflict (see paragraphs 2.5 and 3.35), which prison records confirmed. Regular social visits were supplemented with popular themed family days held every two months for up to 20 families.

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.

An impressive range of partners, including internal departments and external agencies, was involved in reducing reoffending work. The partners provided effective support to meet prisoners' resettlement needs in employment, finance, and accommodation. Many were colocated, and we saw effective information sharing and tasks being allocated on a case-by-case basis. The prison held a monthly partnership meeting to develop this informal coordinated approach, prevent duplication and minimise the risk of partners overlooking a prisoner.

- The prison arranged a monthly pre-release meeting at the employment hub with prisoners with 12 weeks until their release. There they met the partners supporting them so they could understand what action was being taken to help them prepare for their release. However, regime restrictions meant that in the previous six months about 40% of prisoners invited to the meeting had been unable to attend. In these cases, partners attempted to see the prisoner separately, but they told us that sometimes other demands meant this contact would be delayed. For some prisoners with only a short time left to serve, this meant they might not have been seen in person at all.
- The head of reducing reoffending planned to introduce better collection and analysis of data from each of the partners and set measurable targets to systematically improve outcomes for all prisoners. However, the strategy and action plan to achieve this had not yet been fully documented or shared with partners.
- All sentenced prisoners arriving at Brinsford were allocated a prison offender manager (POM) to support them through their sentence. Records indicated that POMs generally contacted prisoners shortly after their arrival, often face to face, which was positive. Contact after this was sporadic, and usually prompted by time-bound processes, such as to compile offender assessment system (OASys) reports. In most of the cases we reviewed, there was little evidence of POMs undertaking proactive one-to-one offence-related work with prisoners to help them reduce their risks (see paragraph 6.22), which sometimes had a negative effect when their security category was reviewed. However, the POMs we spoke to knew and understood the prisoners on their caseload well, and, during the inspection, few prisoners complained about their POM, and many knew their name, which we do not always see.
- While there had been a recent increase in the number of key work sessions, many prisoners still did not have regular support from a key worker. Many of the notes from sessions we reviewed were cursory and conversational, with limited evidence to show key workers were aware of prisoners' sentence plan targets or other needs, for example, relating to their age. (See also paragraph 4.4.)
- 6.11 Most prisoners had an OASys report, including a sentence plan, that had been created in the previous 12 months. Many of the plans we viewed had been prepared by the community offender manager (COM) and had generic targets, such as 'prisoners should improve their behaviour', but they included very little detail explaining what they needed to do achieve this, which could have had a negative impact on the prisoner's ability to demonstrate they had reduced their risks. In our survey, only 37% of those who said they had a custody plan said staff were helping them achieve their targets.
- 6.12 We saw a few examples of prisoners making progress. One of the prisoners who had achieved his target of developing employment skills told us about the positive benefit: 'In other prisons I felt like I was doing time. Here I've been given opportunities to use my time to change my

- life. Now I want to give back to fellow prisoners to help them on their journey to change their lives. Thank you Brinsford.'
- 6.13 The assessments we reviewed also included a risk management plan that listed the action required to prepare for the prisoner's release. While most risk management plans were comprehensive in the range of risks considered, some merely listed generic mitigating action that was not clearly linked to the individual prisoner, although we also saw some very good, individually tailored plans.
- In most of the cases we reviewed, the responsibility for the risk management plan had been transferred to a COM and we saw effective handovers from the POM, supported by appropriate information to help manage the prisoner's risks. In many cases, the COM maintained good contact with the prisoner and provided information about licence conditions. However, a shortage of probation officers in the community meant that occasionally the handover was delayed, which meant the COM had less time to work on the release plan and discuss the content with the prisoner.

Public protection

- In many of the cases we reviewed, the COM took appropriate action to manage public protection as part of the risk management plan, such as conferring with the victim liaison officer, police or local authority children's services department. Communication between the COM and the POM was usually effective enough to make sure that the prison was aware of the action being taken. However, in a small number of cases the POM was not sufficiently involved and was not able to escalate concerns to the senior probation officer at the prison when the risk management work did not appear to be robust enough.
- 6.16 The monthly inter-departmental risk management meeting (IRMM) focused on those approaching release who posed the highest risk of harm to others. However, it did not systematically consider all prisoners who posed a risk to others, such as those with restraining orders. It would not routinely identify instances in such cases where the COM's risk management work was insufficient.
- 6.17 The IRMM checked that the COM had confirmed a prisoner's multiagency public protection arrangement (MAPPA) level before their release. However, the level was often agreed too late to inform their plans, and the decision rarely involved the prison, which meant it was made without including information about the prisoner's behaviour, associates and vulnerabilities. Some of the documents supplied by the prison to MAPPA meetings in the community once the prisoner's level had been set, did not include sufficient analysis of how the information about the prisoner could be relevant in future risk planning.

Categorisation and transfers

- In the previous 12 months, there had been about 90 new arrivals each month, with just over half having been transferred from other establishments and the remainder arriving directly from the court on conviction. In the previous three months, a fifth of all newly arrived prisoners had less than three months to serve, which limited the amount of time available for risk reduction work and release planning.
- 6.19 Arrivals from court were promptly assigned a security categorisation and those who had received a longer sentence were transferred to an appropriate prison to serve their sentence without delay.
- 6.20 Periodic reviews of the security categorisation of prisoners who remained at Brinsford were also completed in a timely manner. However, prisoners were not routinely consulted as part of the review, and some told us they felt frustrated because they could not discuss the progress, they felt they had made.
- 6.21 In the previous 12 months only two prisoners had been categorised as suitable for open conditions. In some of the cases we reviewed, the reason not to recommend a lower security category did not contain sufficient justification. Prisoners were not routinely informed of the reasons why they had not been recommended for open conditions, which had led to some prisoners feeling that decisions had not been made fairly. Some decisions not to recommend a prisoner for open conditions referred to a lack of completed offending behaviour work. (See paragraphs 6.9 and 6.22.)

Interventions

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

- 6.22 Many prisoners arrived at Brinsford before their resettlement in the community having not completed any offence-focused work. We also saw very little evidence of POMs undertaking proactive, structured one-to-one offence-related work with prisoners. (See paragraph 6.9 and 6.21.)
- 6.23 The prison offered two accredited offending behaviour programmes, both aimed at developing a prisoner's thinking skills, one of which was adapted to those with learning difficulties and disabilities. Prisoners who were eligible for these programmes and who had sufficient time left on their sentence, could undertake one before their release.
- 6.24 The prison screened prisoners to identify those with a low level of maturity, but initiatives to support this group, such as the Choices and Changes resource pack, were underdeveloped.

- 6.25 The prison did not offer any interventions to address gang-affiliation issues, although third party providers carried out some limited but innovative work (see paragraph 6.27).
- 6.26 Many prisoners had benefited from a range of one-to-one interventions delivered by resettlement partners, such as PACT and Change, Grow, Live, covering subjects such as emotional well-being, independent living, and personal finances.
- The prison had also collaborated with external partners on innovative projects to improve prisoners' personal development before their release. This included a programme to support young adults develop a positive attitude to working with resettlement services. During the inspection, prisoners on the programme delivered an activity session for children from a pupil referral unit to highlight the negative aspects of prison life. Meanwhile, the Maverick Sounds project helped prisoners express themselves through music.
- The prison employment lead staff member had developed promising relationships with employers (see paragraph 5.19), and job vacancies were advertised at the prison's employment hub, although many prisoners were unable to attend due to the restricted regime. Prisoners received information and advice from several partner agencies, including support to develop CVs and write disclosure letters. The number of prisoners leaving with a job had recently increased.
- An onsite Department for Work and Pensions worker provided prisoners with proactive support to claim benefits. Many prisoners received advice about finances from other partner agencies and some had undertaken a formal money management intervention run by a charity. A dedicated identification and banking adviser supported prisoners to open a bank account before release.

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.

- 6.30 There were about 50 releases each month, mostly in the West Midlands. Prisoners received effective support from the pre-release team, and partner agencies and data suggested that most prisoners had an address to go to on the day of release. Many prisoners had also benefited from the support of a through-the-gate mentor and been referred to an activity hub in the community offering specialist accommodation advice, support for independent living and help to improve life skills.
- 6.31 We saw some excellent examples of work with community partners to meet prisoners' needs. In one case involving a prisoner with additional needs, the POM explained his licence conditions and gave him an easy-read version. He was collected from the prison and taken to meet

- the accommodation worker. He was also allocated a mentor to support him with benefits and shopping and given a supermarket voucher.
- 6.32 However, some prisoners arrived at Brinsford with very little time left to serve. In these cases, prisoners' needs were often not met until the last minute, which caused anxiety. (See paragraph 6.18.)
- 6.33 The prison had received funding to create a flat within the prison for care leavers (a person aged 25 or under, who has been looked after by a local authority) to practise their independent living skills. Construction was still ongoing during the inspection, but the initiative looked promising.
- All prisoners were seen by a member of the pre-release team on the day of their release. In many cases one of the other resettlement partners also saw them to provide information, such as maps and transport timetables, and to answer questions. Some of the partners provided welfare grants to help prisoners with initial expenses, such as for groceries and bedding.

Section 7 Progress on recommendations from the last full inspection

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 2021, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

Leaders and managers should be more visible to support staff, assure themselves that practice reflects their intentions and make sure that progress is made in priority areas.

Not achieved

Prisoners should be subject to suitable levels of supervision and be challenged appropriately by staff when behaving poorly.

Partially achieved

Leaders should make sure that staff use body-worn cameras when responding to incidents; where this has not been possible, a reason should be given in the use of force report.

Not achieved

Prisoners on the segregation unit should have access to a regime that engages them with purposeful activity while segregated.

Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection, in 2021, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

Accommodation and communal areas should be well maintained, suitably equipped, and cleaned regularly. Staff and prisoners should play an active role in maintaining these standards, and monitoring should be robust.

Not achieved

Leaders should consult regularly with prisoners and use data to identify, investigate and address potential discrimination.

Achieved

Recommendations

A clear programme of consistent out-of-cell activities should be available on the inpatient unit, reflecting the agreed care needs of the prisoners residing there.

Not achieved

Prison officers should receive mental health and substance misuse awareness training, to enable them to recognise behaviour requiring referral for assessment.

Not achieved

Purposeful activity

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

At the last inspection, in 2021, outcomes for prisoners were poor against this healthy prison test.

Key recommendations

There should be a concerted effort to maximise both the amount of time that prisoners spend out of their cell and the available purposeful and recreational activity across the prison.

Not achieved

Leaders and managers should provide an appropriate offer in education, training, and work, so that prisoners acquire new knowledge, skills and behaviour, in line with their sentence plans.

Achieved

Leaders and managers should raise prisoners' participation in education, skills, and work rapidly and substantially, according to the advice and guidance that they receive.

Not achieved

Managers should make sure that face-to-face and remote learning reflect the needs of the prisoners, and that this priority is reflected in the allocation process.

Not achieved

Leaders should make sure that there is sufficient resource to support the new curriculum vision, in terms of both staffing and capital investment.

Achieved

Leaders should make sure that, on arrival, prisoners receive an assessment of their additional learning needs, where appropriate, and that this information is used and updated, so that they can progress well in education, skills, and work. **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 2021, outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendation

Managers should make sure that prisoners who are assessed as needing an accredited intervention are able to access it while in custody.

Achieved

Appendix I About our inspections and reports

HM 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, 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 HM 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 outlines the priority and key concerns from the inspection and our judgements 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 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:

Charlie Taylor Chief inspector Ian Dickens Team leader Sumayyah Hussain Inspector **Lindsay Jones** Inspector Sally Lester Inspector **David Owens** Inspector Nadia Syed Inspector Donna Ward Inspector **Grace Edwards** Researcher Emma King Researcher Sam Moses Researcher Helen Ranns Researcher Sam Rasor Researcher

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Jacob Foster Care Quality Commission inspector Matthew Tedstone Care Quality Commission inspector

Dave Everett Ofsted inspector
Tony Gallagher Ofsted inspector
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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

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

Challenge, support and intervention plan (CSIP)

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

Key worker scheme

The key worker scheme operates across the closed male estate and is one element of the Offender Management in Custody (OMiC) model. All prison officers have a caseload of around six prisoners. The aim is to enable staff to develop constructive, motivational relationships with prisoners, which can support and encourage them to work towards positive rehabilitative goals.

Leader

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

Offender management in custody (OMiC)

The Offender Management in Custody (OMiC) model, which has 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.

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.

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