Report on an unannounced inspection of

# HMP Woodhill

by HM Chief Inspector of Prisons

14–25 August 2023

# Contents

# Introduction

Opened in the early 1990s and situated in Milton Keynes, Woodhill has several functions: it is a category B trainer, but also holds a small number of category A prisoners as well as operating as a site for several specialist units and facilities. Although it can hold up 644 adult men when fully operational, the temporary closure of a houseblock due to staff shortage had reduced its capacity to 570, with the actual roll standing at about 514 during the inspection. The focus of our visit was the category B training function, and we will return to inspect the specialist units at a later date.

Following this inspection I wrote to the Secretary of State on 30 August to invoke the Urgent Notification process for HMP Woodhill. In that letter, and in the inspection debriefing paper that accompanied it, I set out the concerns and judgements that had led me to that course of action. Under the Urgent Notification protocol, the Secretary of State commits to respond publicly within 28 days, explaining how outcomes for those detained will be improved. The Secretary of State's response, for which I am grateful, is published with the Urgent Notification letter and debriefing paper on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/.

This is the fifth time we have inspected Woodhill since 2014 and, as the table below shows, there has been a worrying decline in outcomes across all four of our healthy prison tests. Of perhaps greatest concern is that the jail has attracted our lowest healthy prison test scores for both safety and purposeful activity in our three most recent inspections. It was especially troubling to find that none of the recommendations from our 2021 inspection had been achieved; indeed many of the poor outcomes we had previously identified had, in fact, worsened.

**Figure 1: Healthy prison assessments since 2014**

| | Safety | Respect | Purposeful activity | RRP |
|---|---|---|---|---|
| 2023 | 1 | 2 | 1 | 2 |
| 2021 | 1 | 2 | 1 | 2 |
| 2018 | 1 | 3 | 1 | 3 |
| 2015 | 2 | 3 | 3 | 3 |
| 2014 | 2 | 3 | 1 | 2 |

Woodhill was unsafe. In our survey, 71% of prisoners said they had felt unsafe at some point during their stay and almost half said they currently felt unsafe. We found at least 26 prisoners who were self-isolating in their cells in fear for their safety, the prison had the highest rate of serious assaults against staff in the country, and reported incidents of violence at the prison had risen sharply. Consistent with these findings, the use of force against prisoners was the highest in the adult male estate and illicit drug use was widespread, with

positive random mandatory drug tests at 38%, the sixth highest rate in the country.

The rate of reported self-harm was again the highest in the adult male estate. There had been two self-inflicted deaths since the last inspection, and over the last 12 months there had been 853 incidents of self-harm involving 133 individuals, a significant increase since our previous inspection. Arrangements to support new arrivals at the prison were not good enough. First night cells were not always clean, prepared or properly equipped, and induction was very poor.

Prisoner frustration, caused by a lack of access to basic amenities and delays in getting anything done, was evident. Emergency cell call bells often went unanswered for long periods of time, and key work (see Glossary) was non-existent. There were many relatively inexperienced staff who lacked confidence and were not sufficiently supported to challenge poor behaviour, and bullying and intimidation by prisoners was rife. Many prison officers told us they feared for their safety and that morale was low.

A chronic shortage of prison officers remained at the heart of the prison's difficulties; only half of its quota of Band 3 officers were available for operational duties and there was still a 36% shortfall even when staffing resources were supplemented by officers on detached duty from other jails. Almost twice as many officers were leaving than joining, with no expectation that this situation would improve.

The physical infrastructure was run down and neglected. Communal areas of the prison were dirty, and in some parts, filthy. Most wing showers lacked privacy but refurbishment had stalled, and the facilities management service struggled to keep on top of the repair of frequently damaged cells.

The prison was not fulfilling its function as a category B trainer. Although time out of cell had improved since our last inspection, prisoners still spent far too long locked up. Staff shortages meant that work and education were routinely cancelled, and we found that fewer than 25% of the population were attending activities. Prisoners were underemployed and very frustrated by the lack of opportunities for progression. In our survey, only a third of prisoners said their experience in the prison would make them less likely to reoffend in the future, which was much lower than in similar prisons.

Despite these findings, we saw many dedicated staff, working in challenging circumstances, who were doing their very best to care for some complex and vulnerable men. Leadership of this high-risk prison, operating specialist units and holding different categories of prisoner, is a huge challenge, made even harder by a severe and enduring shortage of staff. Local leaders urgently need more support from HMPPS, and the prison needs a complete reset, which first addresses the chronic staff shortage, and then begins to make the prison a safe, decent and purposeful place.

**Charlie Taylor**
HM Chief Inspector of Prisons
September 2023

# What needs to improve at HMP Woodhill

During this inspection we identified 16 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. **A severe shortage of officers was the fundamental strategic challenge facing the prison. It undermined almost all elements of delivery and limited the amount of time unlocked for prisoners, their access to activities and the care they received.**

2. **Levels of violence between prisoners and against staff were among the highest for any prison in England and Wales.** An inexperienced staff group lacked the confidence to challenge poor behaviour by prisoners and there were too few incentives throughout the prison to promote pro-social behaviour. The widespread availability of illicit drugs was also a significant causal factor.

3. **Levels of self-harm were the highest in the adult male estate.** The care and support given to those in crisis was not consistently good enough.

4. **Prisoners spent far too long locked up.** The regime was not working, with activities regularly cancelled, so that even employed prisoners were frequently locked up for more than 21 hours each day. At weekends all prisoners were locked up for almost all the time.

5. **The education curriculum delivered was not sufficiently ambitious or challenging to meet the needs of the prison population.**

6. **Many prisoners were frustrated about the lack of opportunities to progress in their sentence.** Contact between prison offender managers and prisoners was sporadic and key work was non-existent.

## Key concerns

7. **Early days arrangements were not good enough.** Reception and first night processes were weak and induction was very poor.

8. **The amount of force used by staff on prisoners was very high.** There was too little scrutiny for leaders to be confident that all use of force was justified.

9. **Too many prisoners were segregated for excessive periods, in rundown conditions, with access to only a limited regime and little reintegration planning.**

10. **Applications, complaints and consultation processes were weak, and access to basic amenities was poor.**

11. **Prisoners who were acutely unwell, including those who had taken an overdose of illicit drugs and were assessed as an emergency, were not receiving care that met the national guidelines for clinical monitoring or escalation of concerns.**

12. **Prisoners did not have up-to-date assessments of their medication risks and needs, and the queues at the dispensing hatch were not properly supervised.** There was therefore loss of confidentiality and a risk of diversion.

13. **Too few prisoners had sufficient opportunity to raise their levels of skill in English and mathematics, and those with complex needs or with learning difficulties and/or disabilities were not given the necessary support.**

14. **Insufficient purposeful activity was offered to occupy prisoners fully for the core week and punctuality at the activity sessions that did take place was poor.**

15. **The careers information, advice and guidance arrangements were insufficient to provide prisoners with the help they needed to make informed and realistic decisions about their futures.**

16. **Public protection telephone monitoring arrangements were weak.**

# About HMP Woodhill

**Task of the prison/establishment**
HMP Woodhill is a category B training prison.

**Certified normal accommodation and operational capacity (see Glossary of terms)**
Prisoners held at the time of inspection: 514
Baseline certified normal capacity: 644
In-use certified normal capacity: 627
Operational capacity: 570

**Population of the prison**
- 95% of prisoners were serving a sentence of four years or more, or an indeterminate sentence.
- 37% were under 30 years of age.
- 37% were registered as Muslims.
- 63 were foreign national prisoners.
- 229 were unemployed in the prison.
- An average of 15 new receptions arrived each week.
- 79 prisoners had been released into the community in the last 12 months.
- 150 were receiving support for substance use, 30 on opiate substitution treatment.
- 178 were being supported by the mental health team.

**Prison status (public or private) and key providers**
Public

Physical health provider: Central and North West London NHS Foundation Trust (CNWL) (under a sub-contract with Northamptonshire Healthcare Foundation Trust)
Mental health provider: CNWL (under a sub-contract with Northamptonshire Healthcare Foundation Trust)
Substance use treatment provider: CNWL (under a sub-contract with Northamptonshire Healthcare Foundation Trust)
Prison education framework provider: Milton Keynes College
Escort contractor: GEOAmey (north), Serco (south)

**Prison group/Department**
Long-term and high-security prisons group

**Brief history**
HMP Woodhill was opened in 1992. It started as a local prison, but in the late 1990s took on a high-security role as a core local, re-roling to a long-term category B prison in 2020.

**Short description of residential units**
House units 1–4 are divided into two wings, A and B. Each wing on the main house units is designed to hold 60 prisoners in single cells.

House unit 1A – convicted prisoners (a designated unit to hold remand category A prisoners if required)
House units 1B, 2A, 2B, 3A, 3B, 4A – convicted prisoners
House unit 4B – first night and induction centre
House unit 5 – currently closed owing to staff shortfalls
House unit 6 – national close supervision centre (not inspected), separation unit (currently closed) and discrete unit
Clinical assessment unit – health care inpatients
Compass unit – reintegration and additional needs unit

**Name of governor and date in post**
Nicola Marfleet, September 2017

**Leadership changes since the last inspection**
None

**Prison Group Director**
Hannah Lane

**Independent Monitoring Board joint chairs**
Jane McVea and David Ward

**Date of last inspection**
13–24 September 2021

# Section 1 Summary of key findings

## Outcomes for prisoners

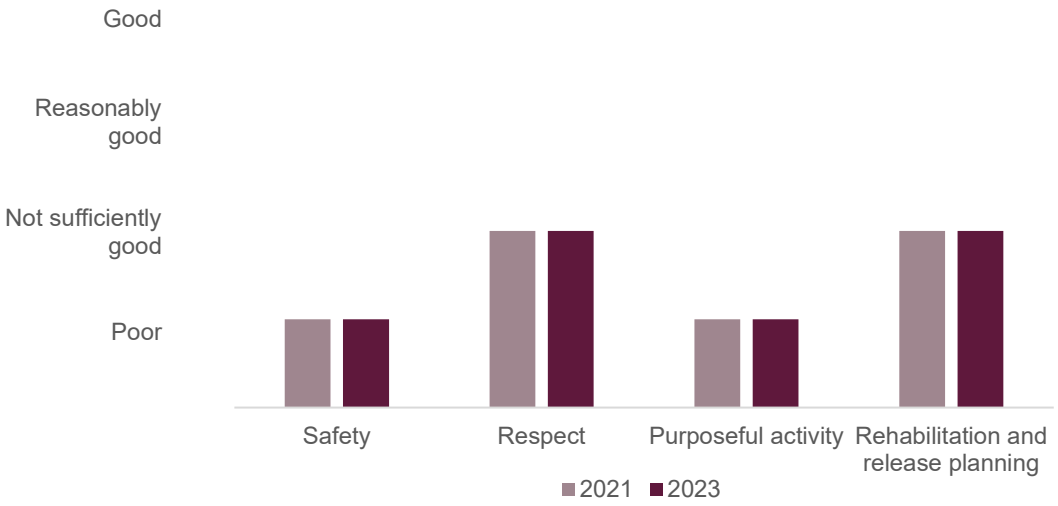
1.1 We assess outcomes for prisoners against four healthy prison tests: safety, respect, purposeful activity, and rehabilitation and release planning (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

1.2 At this inspection of HMP Woodhill, we found that outcomes for prisoners were:

- poor for safety
- not sufficiently good for respect
- poor for purposeful activity
- not sufficiently good for rehabilitation and release planning.

1.3 We last inspected HMP Woodhill in 2021. Figure 1 shows how outcomes for prisoners have changed since the last inspection.

**Figure 2: HMP Woodhill 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 28 recommendations, eight of which were about areas of key concern. The prison fully accepted 24 of the recommendations and partially (or subject to resources) accepted three. It rejected one of the recommendations.

1.5 At this inspection, we found that one of our recommendations about areas of key concern had been partially achieved and seven had not been achieved. One of the two recommendations made in the area of safety was partially achieved and the other was not achieved. All other recommendations were not achieved, including one recommendation in

leadership, two in respect, one in purposeful activity and two in rehabilitation and release planning. 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 one example of notable positive practice during this inspection.

1.8 The chaplaincy participated energetically in the wider life of the prison, including active contributions to mediation and reconciliation, and practical involvement in everyday life and tasks. (See paragraphs 4.34 and 4.35)

# 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 Leadership of this complex and high-risk prison, operating specialist units and holding category A prisoners in addition to its role as a category B trainer, was made especially challenging by the severe and enduring shortage of staff. The poor outcomes identified at the previous inspection had not been addressed and had worsened in some important areas, particularly in relation to safety.

2.3 The prison was unsafe, with the highest rate of serious assaults against staff in England and Wales. The numbers of reported incidents of self-harm and of uses of force were the highest in the male estate, and illicit drug use was a significant problem. Leaders had yet to take effective action to make the prison safer.

2.4 Leaders were not tackling sources of much prisoner frustration that included delays in getting anything done. The many relatively inexperienced staff were not sufficiently supported to challenge poor behaviour, and we found bullying and intimidation by prisoners to be rife. Many prison officers told us that they feared for their safety, and morale was low.

2.5 Despite considerable efforts to recruit and retain staff, a chronic shortage of officers remained at the crux of the prison's difficulties; only half of the prison's quota of band 3 officers were in post and available for operational duties, and there was still a 36% shortfall when supplemented by officers on detached duty from other prisons. More officers were leaving than joining (97 versus 56 in the last 12 months), and a continuing deterioration in staffing was forecast. There were also staffing shortfalls in other grades and areas of the prison, including PE instructors, operational support grades, probation officers and health care staff.

2.6 The prison was not fulfilling its function as a category B trainer; for example, there was insufficient activity. Prisoners were underemployed and very frustrated by the lack of opportunities for progression. In our survey, only a third of prisoners said that their experience in the prison would make them less likely to reoffend in the future, which was much worse than the comparator.

2.7 Leaders had not designed a curriculum to meet the needs of the population, and Ofsted graded the provision as inadequate in all of its

assessments. Activities were often cancelled because of the shortage of officers and the library had been closed since 2020. However, leaders had optimised the use of scarce resources to give regular access to the gym.

2.8 Strategic work to reduce reoffending was weak and the offender management unit remained understaffed, with only around half of probation-employed prison offender managers in post. Delivery of key work to support offender management was non-existent and there were no designated resettlement resources, despite the prison releasing people into the community.

2.9 The run-down physical infrastructure needed investment, and planned improvements for the refurbishment of showers had stalled. The facilities management provider struggled to keep on top of the repair of often-damaged cells.

2.10 The governor and her senior team had shown considerable commitment to the prison over time, although both staff and prisoners told us that they were not sufficiently visible on the units. Effective and capable leadership across all functions was needed to address the prison's critical challenges.

2.11 Many custodial managers and supervisory officers were relatively inexperienced, but we found some strong and dedicated middle leadership and a group of staff that wanted to do a good job.

2.12 The governor had taken robust action to challenge inappropriate behaviour by staff and had communicated a clear set of values for the prison.

2.13 The prison's self-assessment detailed its strengths and weaknesses, but lacked realistic plans for improvement in important areas. It was also uncertain whether some initiatives would have the desired outcome. Concerningly, none of the recommendations following the previous inspection had been achieved.

2.14 Local leaders urgently needed more support to reset the prison. Although a capacity reduction of 74 spaces remained in place, requests to HM Prison and Probation Service for a further reduction had, at the time of the inspection, not been agreed.

# 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 Early days arrangements were not good enough. They had lost focus and were often impeded by staff shortages. In our survey, perceptions of many aspects of the first days at the establishment were more negative than at the time of the previous inspection and at similar prisons. Reception and first night processes were weak and induction was very poor. The absence of readily available, properly structured and consistent peer support was also a missed opportunity to help new arrivals settle in.

3.2 The prison received an average of only 15 new prisoners each week, many of whom had experienced long journeys. Escort vehicles were generally admitted quickly, although some prisoners waited up to 30 minutes to alight. Handcuffing practice was inconsistent and restraints were sometimes used unnecessarily. However, searching procedures were thorough.

3.3 The reception area was not a welcoming environment. The facility was filthy and there was a lack of information on display. All new arrivals saw health care staff, but consultations often lacked privacy. Although the staff were friendly some prisoners waited too long to move to the first night and induction centre.

**Reception area**

3.4 Reception staff were responsible for processing all parcels and property sent into the prison. Despite a recent concerted effort to reduce the backlog of unissued property, including catalogue orders and parcels, the new arrangements were still hampered by staff shortages.

3.5 First night arrangements were also often compromised by the lack of staff. Other than an interview to assess risk, new arrivals generally were given little other support before they were locked up. They received no information about the prison and rarely saw a peer supporter. First night cells were not always clean, well prepared or properly equipped and many prisoners had no working telephone or television, which was a considerable source of frustration.

**A first night cell**

3.6 Induction was very poor and we had little confidence that all prisoners were promptly or comprehensively inducted into life at the establishment. In our survey, only 24% of respondents said that it had covered everything they needed to know, which was worse than at similar prisons and at the time of the previous inspection. There was no structured timetable, interactive presentation or written information. Most new arrivals were seen reasonably quickly by safer custody, mental health and chaplaincy staff, but education and gym inductions were often delayed.

## Managing behaviour

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

### Encouraging positive behaviour

3.7 Levels of violence between prisoners and against staff were very high, and higher than at the time of the previous inspection. There had been 298 incidents of violence in the last 12 months, compared with 182 in

the year before the previous inspection. The number of serious assaults against staff was the highest of all adult male prisons in England and Wales.

3.8 In our survey, 71% of respondents said that they had felt unsafe at some point during their time at the prison, which was worse than at the time of the previous inspection (53%) and at similar prisons (50%). Moreover, 48% said that they currently felt unsafe, which was worse than at other comparable prisons (25%). In addition, 42% said that they had received threats or intimidation from other prisoners, and 44% that they had experienced this from staff, both of which were far worse than elsewhere.

3.9 There was a committed safety team, which was well sighted on the drivers for violence, and every violent incident was investigated. Challenge, support and intervention plans (CSIPs; see Glossary) were the main tool used to manage violent prisoners. Although these plans were very good, with contributions from psychology and offender management staff, they were largely ineffective because too few wing staff were aware of them. The safety team had to chase each recommended action as these were rarely followed through.

3.10 At the time of the inspection there were only seven CSIPS open. No victims of violence were subject to the support element of these plans, which was an oversight. Leaders told us they had kept the number of CSIPs open at any one time low, with the aim of improving focus and quality. However, we found some cases where prisoners should have been challenged or supported through this process but were not.

3.11 A monthly violence reduction tasking meeting considered some additional prisoners who were violent but not subject to a CSIP and provided actions to try to address their behaviour. However, progress was hampered by poor attendance by staff from the residential units, and actions were again rarely completed by wing staff.

3.12 There was also a weekly safety intervention meeting (SIM), which considered all self-isolating prisoners (those who isolated themselves in their cells out of fear for their own safety) and provided some oversight of those prisoners subject to a CSIP. This meeting looked in detail at each case, but the actions were either absent or ineffective.

3.13 The prison regime did not provide sufficient incentive to encourage prisoners to engage positively. The lack of time out of cell (see paragraph 5.1) and limited access to work and education did little to incentivise good behaviour.

3.14 Prisoner perceptions of the rewards and sanctions scheme were poor. Only 23% of respondents to our survey said that they had been treated fairly by the scheme, which was worse than in similar prisons (37%). Prisoners told us that the differential between the levels in the scheme, whereby good behaviour was rewarded with additional privileges such as more gym sessions and spending money, was not sufficient to encourage good behaviour. Staff and prisoners alike told us that

reviews to move up and down levels of the scheme were not timely; well-behaved prisoners had to ask staff repeatedly for a meeting, and those who behaved poorly knew that they were unlikely to be challenged, which undermined the system.

3.15 Staff were also reluctant to challenge poor behaviour for fear of reprisals from prisoners, and they told us that it was easier to let things slide than to enforce the rules (see also paragraph 4.3).

3.16 There were 26 prisoners self-isolating. Reintegration plans were in place for some of them, but they were of poor quality and did not achieve their objective. According to the records, one prisoner had been self-isolating for more than 500 days, and seven others for more than 100.

3.17 The regime for these prisoners was poor; they rarely went outside and were only offered a shower every three days. Some distraction materials were delivered by the safety team and the education department, but we observed squalid conditions for some of these prisoners, who never left their cells, rarely cleaned them and had little meaningful contact with either other prisoners or staff.

3.18 The self-isolating prisoners policy required staff to see them every day, wing managers weekly and someone from the mental health team fortnightly. Records showed that the meetings with a mental health practitioner mostly took place, but case note entries from staff and wing managers were sporadic at best.

**Adjudications**

3.19 There had been an increase in the number of adjudications, with 2,900 disciplinary charges in the last 12 months, compared with 1,512 in the equivalent period before the previous inspection. A large backlog caused delays in charges being heard, and at the time of the inspection there were 186 charges outstanding. Leaders had made efforts to reduce the backlog, but it had recently increased again. Too many charges were laid for less serious offences that could have been dealt with less formally.

3.20 At the time of the inspection, 86 relatively serious charges had been adjourned pending a police investigation, some of them for almost a year. Prison leaders had worked closely with the police to reduce this backlog and the numbers had recently nearly halved, but the situation remained unsatisfactory.

3.21 Too many charges were dismissed because of the delays, further eroding confidence in the system and officers' ability to challenge poor behaviour by prisoners.

3.22 Monthly adjudication standardisation meetings were held to monitor the fairness of the process, but the levels of enquiry we saw in the sample we viewed were generally insufficient, and often charges were not explored thoroughly. Although the deputy governor now conducted

quality assurance of around 10% of all hearings and provided robust written feedback to adjudicators, there was not yet evidence of improvement.

**Use of force**

3.23 The number of incidents involving use of force was the highest per 1,000 prisoners of all adult male prisons in England and Wales. There had been 698 uses of force in the previous 12 months, which was much higher than in the equivalent period before the last inspection (485). In our survey, nearly a quarter of respondents said that they had been restrained at some point during their time at the establishment, which was higher than in comparable prisons.

3.24 PAVA incapacitant spray (see Glossary) had been drawn 32 times in the last year and used on 12 prisoners, while batons had been drawn on 20 occasions and used three times.

3.25 There was now some scrutiny of use of force incidents, but footage of only 30% of all incidents was viewed each month. This scrutiny was in-depth and staff were challenged appropriately when an issue was identified. Footage of all uses of PAVA and batons was viewed, and a defensible decision log, to make sure that each use was fully justified, was completed.

3.26 A coordinator, trained to teach use of force techniques, was scheduled to be deployed each day to attend incidents, debrief all prisoners who had been subject to a use of force, and quality assure the statements of officers. However, these specialist staff were regularly deployed to other duties, leading to long delays in giving prisoners the opportunity to discuss why force had been used or to raise any concern.

3.27 In the sample of closed-circuit television (CCTV) and body-worn camera footage we viewed, which included both PAVA and baton use, most of the force used appeared justified. There was good evidence of de-escalation by staff. The sample included one clear instance of excessive use of force, but this had been identified by leaders and appropriate action had been taken.

3.28 There were enough body-worn video cameras for all operational staff to draw one, and we could see that most did. Usage was increasing and available for about half of all incidents, so needed to improve. The too infrequent usage was a particular problem during the initial stages of incidents and before physical force was applied, as it made it difficult for leaders to be sure that every use of force was fully justified. This had been identified by leaders and there had been some recent improvement.

3.29 ‘Special’ (unfurnished) cells had been used 13 times, for an average of four hours and 40 minutes per use, over the preceding 12 months, an increase since the previous inspection. We saw no evidence of unjustified use and there was appropriate authorisation, both medically and from leaders, for all the instances we checked.

3.30 All prisoners placed into this accommodation were put in anti-ligature clothing normally reserved for prisoners who presented a high risk of serious self-harm, which was inappropriate in all the cases we reviewed.

## Segregation

3.31 The segregation unit was always full and routinely exceeded its capacity of 12 by using an adjoining overspill facility. During the inspection, the number of prisoners segregated fluctuated between 15 and 17. In the last 12 months, 142 prisoners had been segregated. The average length of stay was not accurately recorded although many remained there for long periods; at the time of the inspection, the longest-standing resident had been there since December 2021.

3.32 The environment was run-down and often dirty, and many cells were damaged or out of action. The constant supervision facility was poor, but used often, including for many prisoners who did not need segregation conditions (see also paragraph 3.47). At the time of the inspection, two prisoners on the unit were on assessment, care in custody and teamwork (ACCT) case management for prisoners at risk of suicide or self-harm, and records for these, and others who had been segregated on an ACCT, often lacked a defensible rationale.

3.33 The regime on the unit was often compromised by the large number of prisoners held. Daily showers were rarely permitted; exercise periods, which took place in caged yards, were often shorter than the hour expected; and prisoners were rarely able to collect their own meals from the servery. More positively, many had in-cell telephones and could access books, and efforts were made to engage them with in-cell education packs. However, it remained unacceptable that professionals from a variety of disciplines who visited prisoners could not speak to them in private.

**Segregation unit exercise yard**

3.34 The staff selected to work in the unit lacked specialist training or supervision to work with challenging behaviour. While they did their best to engage with prisoners, only a third of the respondents to our survey who had been segregated said that they had been well treated, which was far more negative than at the time of the previous inspection.

3.35 Segregation was generally only authorised when needed and was reviewed appropriately. However, targets to encourage reintegration were often perfunctory and too few prisoners returned to normal location. A range of data was collated and discussed at a quarterly multidisciplinary group, but issues, such as the consistently high numbers of segregated prisoners and their long stays, were not generally addressed.

3.36 Some prisoners also experienced segregation conditions on normal location, for reasons that included suspected secretion of illicit items, a pending adjudication and, what sometimes appeared to be, staff discretion. The oversight of this ungoverned segregation was lacking and often involved prisoners receiving an impoverished, if any, regime.

3.37 The establishment also housed a small number of prisoners in a designated close supervision centre (CSC; see Glossary). The CSC was not inspected at the present inspection, as it was due to be part of

a more detailed estate-wide inspection of similar facilities at a later date.

## 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.

3.38 Security processes were well managed and staff across the prison maintained a good flow of information into the security department; about 15,000 reports had been processed in the last year. Security procedures were mostly proportionate to the risk presented by the prisoner population.

3.39 The security department was well resourced, with a dedicated search team and patrol dog section. This gave leaders the flexibility to respond to information received and identify threats. There was rarely a backlog of information reports, and when this occurred an effective triage system made sure that urgent issues were acted on quickly.

3.40 There was a wide range of well-attended security meetings. The local tactical assessment was very detailed and contained an accurate assessment of the risks to the prison. The security objectives for the prison were disseminated well and a notice to staff was published each month. Most of the staff we spoke to were aware of these objectives.

3.41 The supply of illicit drugs into the prison was a considerable problem despite significant gate and perimeter security; the random mandatory drug testing positive rate was the sixth highest of all adult male prisons, with 38% of prisoners testing positive between April and July 2023. In our survey, 42% of respondents said that it was easy to get illicit drugs at the prison, and 41% that it was easy to get alcohol.

3.42 Although the supply of drugs had been identified as a serious threat there was also no consolidated action plan which brought all elements of supply reduction into one place. This meant that the response was fragmented and viewed by staff as the responsibility of security staff, rather than that of the whole prison, limiting the impact of some actions.

3.43 Leaders had responded to some of the information they had received by, for example, deploying patrol dogs outside the prison to prevent packages being thrown over, sending notices to the local community to reduce drone traffic and photocopying all mail, to intercept paper impregnated with psychoactive substances.

3.44 Despite these efforts, the supply of illicit substances into the prison was not reducing, and bullying associated with the debt generated by their use was a key identified driver of violence.

## 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

3.45 The prison managed a complex and vulnerable population, but the approach to preventing and reducing self-harm and suicide was inadequate. The level of reported self-harm for the last 12 months was the highest in the male estate. During this period, there had been 829 incidents of self-harm, involving 128 individuals, which represented an increase of almost 40% since the previous inspection.

3.46 There had been two self-inflicted deaths since the previous inspection. Learning from some Prisons and Probation Ombudsman recommendations was not fully embedded. It was a matter of concern that many prisoners continued to cover the observation panels in their cell doors, which often prevented proper welfare checks from being conducted.

3.47 In the previous year, 46 prisoners at serious risk of suicide or self-harm had been subject to constant supervision. Although cells adapted for this purpose were present on most house units, they were often not free for their intended purpose. As a result, just under half of prisoners needing constant supervision were segregated, in a cell that was dirty and poorly equipped (see also paragraph 3.32). The prison maintained no log of the use of anti-ligature clothing, and we found evidence of prisoners' own clothing being removed without proper justification, which at times also appeared punitive.

**Segregation constant supervision facility**

3.48 A wide range of data was collated, analysed and discussed at the monthly safer custody meeting. As a result, leaders were aware of the drivers for self-harm, which included frustration about the lack of access to basic amenities, such as a telephone, television and kettle, alongside poor mental well-being, debt issues, and a lack of purposeful activity and opportunities to progress. The safer custody action plan was not properly focused and leaders' responses to the issues, which persisted month after month, were inadequate.

3.49 ACCT case management documents had been used 229 times in the previous year. All prisoners on an ACCT were discussed at the SIM (see also paragraph 3.12), but, again, there was little sense of action to address individual need. Arrangements for those considered by the multi-disciplinary complex case meeting were better.

3.50 Despite efforts by the safer custody team to upskill staff, there were frailties in the ACCT process and quality assurance was absent or ineffective. Inconsistent case management was a source of frustration for those in crisis and, if completed at all, individual care plans often lacked proper focus. Observations were not always conducted at the required frequency and interactions were often transactional. In our survey, only 17% of respondents who had been on an ACCT said that they had felt cared for, although most we spoke to cited at least some

helpful support from individual officers and/or specialists, including psychologists and mental health practitioners.

3.51 It was worrying that some prisoners on an ACCT had no access to a working emergency cell call bell and some told us that their cell call bells were not always responded to promptly. Throughout the inspection, we saw cell call bells going unanswered for sometimes long periods (see also paragraph 4.14).

3.52 Most incidents of serious self-harm were reviewed promptly. However, the quality of investigations varied and generally only reviewed written evidence, rather than including a conversation with those involved. Despite this, some learning was generated.

3.53 We were not confident that access to one of the 12 Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) was good enough, and there was no dedicated facility used for them to see callers. Direct access to the Samaritans was impeded by a lack of working telephones.

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

3.54 Although the governor attended the local safeguarding adults board, leadership and ownership of the prison's arrangements had slipped. The local policy was adequate, but staff awareness was limited, and they were not always properly sighted on how to raise a concern.

# Section 4 Respect

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

## Staff-prisoner relationships

Expected outcomes: Prisoners are treated with respect by staff throughout their time in custody and are encouraged to take responsibility for their own actions and decisions.

4.1 In our survey, 61% of respondents said that staff treated them with respect, which was similar to the figure at comparable establishments. However, fewer than in similar prisons reported positive relationships; only a fifth of those responding said that they had been spoken to by staff in the last week, and 27% said that they felt treated as an individual.

4.2 Staff shortages had worsened since the last inspection. Many officers lacked experience in their roles or were on detached duty from other prisons. Prisoners were frustrated because staff could not answer their questions and did not have time to respond to legitimate requests or to complete promised actions.

4.3 Some officers lacked the confidence to enforce basic rules and challenge poor behaviour. Although leaders had introduced a 'new colleague mentor' team to provide supervision, support for new staff was still too limited because supervisory officers were often deployed to other units to fill staffing gaps.

4.4 However, some prisoners told us that officers were doing their best in difficult conditions. We saw mostly positive interactions between prisoners and staff, and observed officers out on the wings engaging with prisoners. It was clear that many officers cared about the welfare of prisoners and supported them as well as they could.

4.5 Key work (see Glossary) was not being delivered. Most prisoners had not met their key worker and were unclear about the process.

4.6 Peer support was underdeveloped. There was a team of trained Listeners, and most units had one or two Insiders (prisoners who introduce new arrivals to prison life). There was little support for these mentors, or oversight of their work.

## 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

Most outside areas were reasonably attractive, and new tree planting and wildlife garden areas had been established to soften the external environment. Wing yards were tidy and free from litter, and had some fixed exercise equipment.

4.7 Cells in the house units were arranged around an open communal atrium which was well lit by large windows, and had the potential to be an attractive environment. However, many of these indoor spaces were unacceptably dirty, and some corridors and stairs were filthy. Some highly visible areas, such as the ledges above the windows, were strewn with rubbish.

**Dirty window ledge**

4.8 Although about 14 prisoners were employed as cleaners on each unit, they were often locked up during work periods because of staff shortages. When they were working, levels of cleanliness on most house units were poor because of a lack of cleaning protocols and inadequate supervision by staff. In our survey, only 26% of

respondents said that communal areas were clean, which was far less than at comparator prisons.

4.9 All prisoners were housed in single cells with internal sanitation. Cells provided adequate space, but their condition varied. Many needed repainting, and floor coverings were often worn out and difficult to clean. However, the supply of cleaning materials had improved and some cells were maintained well by their occupants.

4.10 Although managers had recently introduced weekly cell fabric checks, too many cells had long-standing defects, such as broken toilet seats, lights and windows. Many lacked adequate storage for prisoners' clothes and possessions. Prisoners were particularly frustrated by long delays in repairing or replacing broken in-cell telephones.

4.11 Repairs to cells damaged by prisoners took too long, which sometimes led to a lack of suitable accommodation. As a result, staff sometimes resorted to locating prisoners in unacceptable conditions. We found one vulnerable prisoner who was housed in a cell without an emergency call bell, although managers addressed this when we raised it with them. Another prisoner spent at least two days during the inspection in a cell without running water or a toilet.

4.12 Prisoners could access a shower every day, but shower rooms on most wings lacked privacy, had poor drainage and were often very dirty. On three units, the showers had been refurbished, with cubicles installed, which was an improvement. Plans to improve showers on the other units had been long delayed.

4.13 Most prisoners wore their own clothes, but, for those who needed them, supplies of prison clothing and bedding were erratic, with long delays in supplying basic items such as underwear and sheets. Each unit had a laundry, but some washing machines were out of order.

4.14 In our survey, only 8% of respondents said that their emergency cell call bells were answered within five minutes. Prison records showed that almost half were not answered within this target time, and almost a quarter waited longer than 10 minutes. Records of cell call bell response times were available to managers, but there was insufficient analysis of them to improve performance. Prisoners told us that their lack of confidence in staff responding to cell bells in an emergency was a significant factor in causing them to feel unsafe (see paragraph 3.8).

**Residential services**

4.15 In our survey, only 20% of respondents said that the prison food was good, and only 21% that they got enough to eat; both of these results were similar to those at the time of the previous inspection, but worse than in similar prisons.

4.16 Prisoners received one hot meal and one cold light meal each day, plus a small breakfast pack. Some of the hot meals we saw were acceptable, but others were unappetising. Kitchen staff shortages

reduced the number of meals that could be freshly prepared, so many were based on bought-in food, which reduced their quality. Servings of carbohydrate foods such as rice and potatoes were substantial, but portions of the protein elements were often too small. The breakfast packs and most of the cold meals were also insufficient. The menus were not analysed to make sure that they were nutritionally adequate.

4.17 Meals were served too early. We saw lunch being served at 11.10am, and dinner at 4.15pm on some units, which was before all prisoners had returned from activities; this meant that they generally joined the queue on their return, which was not satisfactory. Staff did not supervise the serving of food adequately and some prisoners were given more than their share. Servery workers had been trained in food hygiene, but serveries were not always cleaned thoroughly after use.

**Servery**

4.18 The kitchen and the food trolleys were clean and most equipment was working. Prisoners working in the kitchen were trained in food hygiene and one was working towards a vocational qualification in catering, delivered by the education provider.

4.19 The kitchen manager attended the prisoner council (see paragraph 4.22) and sometimes visited serveries at mealtimes, but there was no regular consultation with prisoners about the food.

4.20 Opportunities for prisoners to cook for themselves were too limited. Self-catering rooms had been introduced on the house units, but a lack of ventilation restricted cooking options. Most contained only toasters and microwave ovens.

4.21 The prison shop list included a wide range of products, and in our survey 43% of respondents said that they could buy the items they needed. However, far fewer prisoners from black and minority ethnic backgrounds than white prisoners said this. Prisoners complained that prices had risen while their wages had remained static, so many items were unaffordable. The list included fresh fruit and vegetables, but prisoners said that these often arrived in very poor condition.

**Prisoner consultation, applications and redress**

4.22 Prisoner consultation had only recently restarted. The prisoner council had met monthly in the last three months, and wing forums had taken place on house unit 3 and in the specialist units. In our survey, only 28% of respondents said that they had been consulted about everyday topics such as food, prison shop, health care or wing issues, which was considerably less than at comparable prisons (52%) and at the time of the previous inspection (47%).

4.23 The applications process was not well organised. Wing staff no longer kept logs of applications received, or of those sent to other departments, so there was no possibility of tracking the receipt of responses. In our survey, only 14% of respondents said that applications were usually dealt with within 14 days, compared with 27% elsewhere, and 27% said that they were usually dealt with fairly, against 43% in comparable prisons.

4.24 The shortfalls with consultation and applications probably contributed to the high level of complaints, with an average of 711 a month submitted over the last year. Only 14% of our survey respondents said that complaints were dealt with fairly, and responses were often late. The replies to complaints were courteous and addressed the issue raised by the prisoner, but in many cases they had not been spoken to, or the issue investigated sufficiently.

4.25 Facilities for legal visits were good, including five video booths, although in our survey fewer than in similar prisons said that it was easy to communicate with their solicitor or legal representative. The library stocked the important legal books; as it was not open (see paragraph 5.5), library staff visited all the wings regularly and photocopied sections in response to individual requests.

## 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 Equality and diversity work had stalled almost completely until the recent creation of a new adviser post, two months before the inspection. An ambitious action plan had been devised, but so far lacked detailed actions and timescales. There had been limited progress so far – for example, in the use of data or arranging of special events. Our survey did not highlight any clear issues in terms of differential experiences among minority groups.

4.27 A quarter of the population were black or black British, and 10% were Asian or Asian British. Some good work had been done over a five-month period to listen carefully to the experience of black prisoners and to identify appropriate actions; a podcast was in preparation on this topic by both prisoners and staff. The chaplaincy was engaging with the Traveller community, using St Patrick's day as an occasion for celebration.

4.28 Support for foreign nationals had diminished and, although our survey showed few statistically different perceptions to those of British nationals, those who did not speak or read English proficiently were not well served. There was no record of use of professional telephone interpreting services and we were told that the handset available for this purpose had not been used for eight months. There was little contact with Home Office Immigration Enforcement for those with immigration issues; there had been one visit in several months, when only the few prisoners invited by the immigration officer could see them. No one in the offender management unit had up-to-date training in immigration matters.

4.29 Many of those with disabilities were given appropriate support and adjustments, especially by the health care team. The clinical assessment and Compass units provided good support for some prisoners with a range of disabilities. Some peer support orderlies had recently been appointed, with job descriptions in place, but had not yet formally started work or received any training (see also paragraph 4.66).

4.30 Senior leaders had very recently each been allocated responsibility for a particular protected characteristic. Active leadership was needed; for example, there was no support or encouragement for gay and bisexual prisoners, and there was evidence that almost all gay prisoners chose not to disclose this aspect of their identity. One prisoner commented in

our survey that, of seven prisons he had been in, this was the only one where he did not feel safe or that he belonged.

4.31 There were similar gaps for younger and older prisoners. There was no specific provision for older prisoners, such as gym sessions or other activities. The younger age group also needed more consideration and consultation. In our survey, only 13% of respondents aged under 25 said that their experiences in the prison had made them less likely to reoffend.

4.32 In our survey, 40% of respondents said that they had previously been in local authority care. One of the prison offender managers was working hard to support this group and to liaise with local authority personal advisers for any prisoners under 25. A supervising officer looked out for those who had served in the armed forces, and linked well with SSAFA (the armed forces charity) and other external organisations. A neurodiversity support manager was due to take up post shortly, but at the time of the inspection there was little organised support, although some useful help was being given to a prisoner with autism spectrum disorder.

**Faith and religion**

4.33 A strong and united chaplaincy provided a full range of worship and religious study. In our survey, 88% of respondents said that they could attend religious services if they wanted to, which was better than in comparable prisons (76%). There was a varied programme of worship and religious discussion, with lively and prominent external speakers.

4.34 Friday prayers for the Muslim community of almost 200 prisoners was provided for half the prison on alternate weeks because of risks arising from rivalries between some individuals and groups. The chaplains had worked hard on this issue, undertaking mediation and speaking privately to key individuals. The chapel had been agreed as a safe zone, and Muslim prisoners appreciated the very clear information about rules and practices in relation to faith at the establishment, given to each of them on a well-designed chaplaincy fact sheet.

4.35 The chaplaincy exerted an energetic influence throughout the prison. Chaplaincy volunteers from the community were each assigned to a wing, to visit it regularly and build relationships, while chaplains had increased their impact through undertaking practical tasks such as serving food during a significant incident. They had also given practical support to those being released, including linking them to faith communities in their locality.

## 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.

### Strategy, clinical governance and partnerships

4.36 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 issued 'requirement to improve' notices following the inspection (see Appendix III).

4.37 Northampton Healthcare NHS Foundation Trust subcontracted the service to Central and North West London NHS Foundation Trust (CNWL), which delivered physical and mental health, substance misuse and social care services. Time for Teeth had been commissioned to provide dental care.

4.38 The health and social care needs assessment needed updating and NHS England told us that there was a backlog to produce an up-to-date one.

4.39 Although prison leaders attended the quarterly contract review, there had been no local delivery board or partnership board meetings since the start of the COVID-19 pandemic. Draft terms of reference for a local delivery board were drawn up after we raised the issue.

4.40 The memorandum of understanding for social care between Milton Keynes Council, CNWL and the prison was under review. This partnership working needed strengthening as the monitoring of referrals, assessments and reviews did not ensure good oversight or a prompt response to patient need.

4.41 Health services were well led by a strong clinical management team. Staff were kind and conscientious, and we noted mutual support across the clinical disciplines, focusing on patient care. There were staff vacancies in all areas. Recruitment was in progress and regular agency staff were used to cover deficits.

4.42 Clinical governance processes were in place and although many incidents were reported and investigated, we identified one serious incident which had not been reported as required. This meant that a thorough investigation had not taken place and lessons could not be identified to inform future care.

4.43 There was insufficient governance of the use of video sensor units in the clinical assessment unit. The sensors were present in every cell and could be used to monitor the prisoner’s pulse and respiration rate. There was an inadequate process to obtain patient consent for this, the

monitoring was not included in care plans and, as a routine practice, it was intrusive and unnecessary.

4.44 Compliance with mandatory training was satisfactory and professional development was encouraged. Managerial and clinical supervision were embedded in practice. An external facilitator delivered regular reflective practice sessions.

4.45 CNWL collected patient feedback and had responded to this by making changes to services where appropriate and displaying 'You said, we did' posters.

4.46 Regular infection control audits were conducted, but there were some outstanding concerns that needed to be addressed, including the replacement of flooring. This had been raised with the prison and had yet to be resolved. Clinical equipment was calibrated each year.

4.47 The environment in the clinical assessment and Compass units was stark and lacked décor that might contribute to health and well-being. There was a missed opportunity to display health promotion information.

4.48 The range of clinical records we looked at were satisfactory. Individual care plans were reviewed regularly, but those for prisoners with long-term conditions were often generic and lacked patient participation.

4.49 All health care staff were trained in intermediate life support and had good access to emergency equipment. The emergency bags were well maintained and regularly checked, but were very heavy, at 15.5kg, with no trolley to transport them safely. This posed a health-and-safety risk to the individual carrying a bag in an emergency.

4.50 Patients told us, and we observed, that there were not enough health care complaint forms on the units. This meant that such complaints were submitted through the prison system, which was not confidential. Responses were polite, timely, addressed the patient's concerns and told them how to escalate the complaint if unhappy with the outcome. Face-to-face resolution was used, but not well recorded.

**Promoting health and well-being**

4.51 There was no whole-prison strategic approach to health promotion. The health care team had developed a calendar of events, based on national health promotion programmes. Health care staff contacted the gym and/or kitchen, when required, for their support and involvement.

4.52 Health promotion leaflets were displayed across the prison as events took place. We were told that information could be translated if needed.

4.53 NHS health checks and a range of prevention screening programmes were offered. Immunisation was available, but patient uptake of vaccinations had been poor following the COVID-19 pandemic and they were often declined.

4.54 Sexual health services were available and practice nurses referred to a local hospital if specialist treatment was needed.

**Primary care and inpatient services**

4.55 The GP and nurse-led clinics were available from Monday to Friday, with emergency nurse cover at the weekend. There was nurse cover on the clinical assessment unit 24 hours a day, seven days a week. The service employed practice nurses in addition to wing nurses, who ran triage clinics, and reception and secondary health screens, and administered medication.

4.56 Despite a high staff vacancy rate within primary care, patients had good access to all services, with most seen within two days.

4.57 Nursing staff screened new arrivals in a dedicated private room in reception. However, we noted that they did not always keep the door closed during consultations, which meant that confidentiality was not assured.

4.58 Patient applications were processed and triaged, and they were seen promptly by the relevant clinical professional.

4.59 Prisoners with a long-term condition were identified and reviews took place, although the care plans were not always personalised and did not always follow national guidelines.

4.60 An emergency responder was allocated to each shift and attended all health care emergencies. We identified that the clinical monitoring of patients who experienced an urgent or emergency response did not consistently receive adequate clinical monitoring following each incident, and concerns about the patient were not always escalated appropriately. The health care provider's policy on monitoring patients who had taken an accidental overdose of illicit drugs did not reflect national guidelines on NEWS2 (see Glossary). We raised this with the head of health care as a matter to be addressed promptly.

4.61 Waiting times to see a range of visiting practitioners and allied health care professionals, including a physiotherapist, optician and podiatrist, were acceptable.

4.62 Patients who needed an outpatient appointment or emergency visit to a local hospital were transported by officers in a dedicated taxi service, although the prison often cancelled escorts at short notice because of staff shortages. However, there was no contract for transporting patients who needed to use a wheelchair, and since June 2023 these patients had had their external hospital appointments cancelled.

4.63 Primary care nurses identified patients due for release and saw each one individually to prepare for their ongoing care, which included providing a letter for their GP.

## Social care

4.64 No patients were in receipt of a social care package (see Glossary). Health care staff identified those needing referral to the local authority, but there were unacceptably long delays in assessments being carried out. In the interim, primary care staff and the prison worked collaboratively to make sure that patient needs were met.

4.65 Self-referral to the local authority was not advertised or promoted. In addition, prison staff had limited knowledge about who to contact to make a referral, which needed addressing.

4.66 Peer support orderlies had been appointed to help patients with low-level needs. However, there was no formal recruitment, training or supervision, which posed a risk to patient safety. The equality adviser was reviewing the service to resolve this (see also paragraph 4.29).

4.67 Equipment, such as wheelchairs, was available, but there were no personal alarms available for patients to summon help.

4.68 There was evidence of partnership working to support those leaving the prison who needed ongoing care.

## Mental health care

4.69 In our survey, 65% of respondents said that they had a mental health problem. CNWL provided mental health and psychological therapies, which were available from Monday to Friday, 8am to 4pm, with an on-call service for out-of-hours managerial support.

4.70 The team had significant staff vacancies, but recruitment was ongoing. A highly skilled team delivered a range of support to prisoners.

4.71 All new prisoners received a mental health screen within 72 hours of arrival. In addition to self-referral, referrals could come from professionals and support staff across the prison. All referrals were triaged daily and allocated for assessment, and a full referrals meeting was held weekly.

4.72 At the time of the inspection, the team was supporting 178 patients, which included 41 on the care programme approach (a specialist approach to caring for patients with complex needs). The team met each week in a multidisciplinary forum to review patient risk of harm (either to themselves or others), care and treatment.

4.73 The range of interventions on offer included one-to-one support and the stepped care programme, with groups for anxiety and depression.

4.74 The stabilisation, progression and rehabilitation programme worked with patients who had the most complex clinical needs and struggled to engage with services. This included participation in theatre and music groups that explored aspects of emotional and psychological health. Patients we spoke to were highly complimentary about the programme

and the positive impact it had made on their behaviour and mental health.

4.75 Effective links with the addictions team supported those with substance use and mental health concerns. The primary care team completed physical health checks for patients on the mental health team caseload.

4.76 There was a weekly multidisciplinary complex care meeting, attended by mental health practitioners; this was well documented, with patient key risks and changes to care plans noted, and was good practice.

4.77 There had been no mental health awareness training for officers for over a year and there was no date for it to restart. Officers we spoke to were keen to have training and recognised it as a deficit in their skills and knowledge.

4.78 Health care staff attended assessment, care in custody and teamwork (ACCT) case management reviews.

4.79 There were psychology groups, but there were long waiting lists, so patients were supported by regular welfare checks in the meantime.

4.80 All referrals made to mental health facilities for transfer under the Mental Health Act had breached the national guideline of completion within 28 days. In the previous six months, four patients had waited for an excessive time, the longest wait being 147 days, despite escalation by the team.

4.81 Nurses contacted community mental health teams in advance of patients' release, to enable support to be in place for them once they left prison.

**Substance misuse treatment**

4.82 CNWL delivered an integrated clinical and psychosocial substance misuse service. Managers provided strong leadership to a highly motivated team. There was a drug strategy, and the working relationship between the service and the prison was positive, but these had yet to have an impact on illicit drug use.

4.83 A total of 21 patients were receiving opiate substitution treatment (OST) and 150 patients were supported by the psychosocial team. Those we spoke to were complimentary about the support they received, and we observed caring interactions.

4.84 Prisoners who arrived on OST were reviewed promptly by a non-medical prescriber (NMP) and all of these patients were seen by the psychosocial team within 24 hours.

4.85 Patients were reviewed regularly and jointly by an NMP and a psychosocial worker, which was good practice, and flexible prescribing was in place.

4.86 Prisoners found to be under the influence of illicit substances were seen initially by health care staff; the psychosocial team then delivered harm reduction advice. Some new prison officers had received training on illicit substances, which was positive.

4.87 There was an open referral system and prisoners could self-refer. Staffing challenges had had an impact on waiting times for assessment, but patients' needs were prioritised according to risk.

4.88 Psychosocial plans of care focused on individualised goals, but clinical care plans were not in place, which was not in line with national guidance.

4.89 One-to-one work delivered a good range of support. Formal processes were in place to re-engage with patients who had withdrawn from the service. There were no peer workers. Service user feedback was used to improve service delivery.

4.90 Group sessions were not offered because of a lack of room and prison officer availability, which was a gap in support. Mutual aid groups did not attend the prison.

4.91 Joint working with prison and community services supported patients on release and naloxone (an opiate reversal agent) was available.

**Medicines optimisation and pharmacy services**

4.92 Pharmacy services were provided by a highly skilled and experienced team consisting of pharmacists and pharmacy technicians, who followed up-to-date procedures. Prisoners could ask to see a pharmacist, but there were no pharmacist-led clinics or medicine reviews.

4.93 Most aspects of stock management and storage, including controlled drugs, were appropriate and there was a robust procedure for recording and learning from errors. However, in-possession (IP) and night-time medicines were not separated, which ran the risk of a prisoner receiving another's medication. We raised this issue with the pharmacy team while we were on-site. There were suitable arrangements for transporting medication around the prison.

4.94 Prescribing and administration were recorded on SystmOne (the electronic clinical record) and the pharmacists analysed these data to identify trends.

4.95 There was out-of-hours provision for medicines, which were kept in a dedicated cupboard. Prisoners were able to receive over-the-counter remedies, such as paracetamol, to treat minor ailments.

4.96 Few prisoners had their medication IP. Following a computer upgrade, historical IP risk assessments could not be easily seen; this meant that health care professionals did not have full access to information, which potentially prevented them from making an accurate assessment. We

raised this with the head of health care, and it was found that one-third of patients did not have an up-to-date IP risk assessment.

4.97 Patients stored their IP medicines in cupboards in the single occupancy cells. Cell checks, which included medication, were undertaken by the prison, but the pharmacy team was not involved. This was a missed opportunity to provide advice or collaborate on decisions made about a prisoner's IP status.

4.98 Medicines administration took place four times a day, but did not always meet the necessary standard of safe practice. We raised this with the head of health care, who promptly addressed it through a staff briefing. Patients were routinely asked for their identity card before their medication was supplied, which was appropriate.

4.99 We observed crowding around the medication hatch, which compromised confidentiality and increased the opportunity for diversion and bullying, and prison officer supervision of queues was variable.

4.100 Prisoners were given sufficient medication when attending court or being released.

**Dental services and oral health**

4.101 The newly commissioned dental service provided six sessions a week. Waiting times for routine appointments were about six to eight weeks, although a few patients waited longer.

4.102 The health care and dental teams triaged patients and offered any necessary pain relief for those waiting for an appointment. The dental nurse provided advice on teeth and gum care.

4.103 The care records we reviewed showed that the treatment provided was well documented and that patients had been informed of possible treatment options.

4.104 The use of X-rays and their clinical justification were documented and supported by recent audits.

4.105 The dental surgery was functional and equipment was well maintained. We noted that the ultrasonic scaler had recently stopped working and the dentist planned to request for this to be repaired.

4.106 There was an enhanced air purification system in place. There was a separate decontamination area and decontamination procedures were followed. Infection control standards were generally met, with the exception of an area of the flooring which was damaged and also a broken cupboard. We were assured that the prison was in the process of arranging for this to be repaired.

4.107 The dental team currently shared emergency medicines with the health care team; these were located next to the dental suite, enabling prompt access.

# 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 Although time out of cell had improved, prisoners still spent far too long locked up. Managers had halved prisoner unemployment since the previous inspection by making most prison jobs and education places part-time. As a result, three-quarters of the population now had an activity place. However, regime activities were often cancelled because of staff shortages, so prisoners remained locked up. When we carried out roll checks, we found that, on average, less than a quarter of the population was attending activities.

5.2 All prisoners were unlocked on their house units for domestic activities such as showering and cell cleaning for around 2.75 hours every day. Within that time, they could also spend one hour exercising in the yard outside. There were few recreational activities on the units to occupy them during their time unlocked.

5.3 Employed prisoners had up to 5.75 hours unlocked per day when activities were not cancelled. A small number of full-time kitchen workers were out their cells for 6.25 hours a day. At weekends, there were no activities, so all prisoners were locked up for almost 22 hours each day.

5.4 Many prisoners told us that their well-being had suffered as a result of being locked up for long periods. In our survey, only 22% of respondents said that they were able to lead a healthy lifestyle (in relation to their physical, mental, emotional, and social well-being), which was far worse than at comparable prisons.

5.5 The library was well located in the education department, but it was closed because there were insufficient officers to patrol the area. Despite this, more than half the prisoners were borrowers. Although no orderlies were employed to assist, the librarian and her staff made considerable efforts to maintain the service. They visited house units regularly during prisoners' domestic sessions, to talk to prisoners about their reading interests and encourage them to request books, which they then delivered to the wings.

5.6 The book stock was large and in good condition. It included an appropriate range of materials to meet the needs of different groups

within the population, including foreign language collections, books in large print and books suitable for beginner readers. There was a small stock of audio books, but no music CDs or films on DVD.

5.7 As a result of the lack of access, there were few reader development activities. Storybook Dads (in which prisoners record stories for their children) was provided by the chaplaincy. There was a small stock of children's books, so that prisoners could read them to their children over the telephone.

5.8 Library staff recorded data on loans, including the age and ethnicity of borrowers, to help guide future purchases and monitor equality of access.

5.9 The gym was very popular and access was good. Those on the enhanced privilege level could attend four times a week, and others three times. Managers prioritised gym attendance, and in our survey, 61% of respondents said that they could exercise twice a week or more, which was much better than elsewhere and at the time of the previous inspection. However, there were no evening or weekend sessions.

5.10 There was a substantial shortage of trained officers. Only three of the eight PE instructor posts were filled, and they were assisted by three officers who had basic qualifications, enabling them to supervise sports and games. Training had been arranged over the coming year, to increase the number of qualified instructors.

5.11 The gym was well equipped, with good facilities for weights and cardiovascular fitness training, and a large sports hall for tennis, badminton and indoor cricket games. The outdoor artificial turf pitch was used regularly and PE staff ran a popular inter-unit football league. There were no accredited PE courses. There was a limited range of provision for those with additional needs, such as those on the clinical assessment and Compass units.

## 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.

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

Overall effectiveness: Inadequate

Quality of education: Inadequate

Behaviour and attitudes: Inadequate

Personal development: Inadequate

Leadership and management: Inadequate

5.13 Leaders acknowledged that the curriculum failed to support the delivery of the prison's training function and strategic aims. They had been too slow in implementing an education, skills and work (ESW) curriculum that satisfied the different requirements of prisoners serving the full range of custodial sentences. None of the recommendations made at the previous inspection had been achieved.

5.14 Leaders had failed to provide an ambitious and challenging curriculum. Its range and variety were too narrow, and most of it was at level 1 or below. It offered insufficient access to an appropriate breadth and level of accredited vocational training. Prisoners attending workshops or work were unable to study for accredited qualifications or have their development promoted, recognised and recorded. Most prisoners had no opportunity to improve their digital information and communications technology skills.

5.15 Leaders had not established an appropriate curriculum offer for prisoners with high-level starting points. Very few prisoners participated in open learning or distance learning. Promotion of these study options was poor, despite the prison's own survey showing that not enough prisoners knew about them.

5.16 Leaders had not made sure that prisoners could attend ESW for all the hours of the core week. Almost all purposeful activity was offered only on a part-time basis, with enough places to occupy 86% of available prisoners. The use of places was not maximised and activity sessions routinely ran on very low numbers. Education classes were only available four days a week. Prisoners could not combine work and training sessions to help their development.

5.17 Leaders had not established a consistent and predictable regime that occupied prisoners for the planned hours. Sessions were often cancelled because of a shortage of prison staff to supervise prisoners, or of teachers and trainers to cover for holiday absence. This was reflected in our survey, where respondents' responses about attending education and training sessions were negative. They regularly left

sessions early to attend other appointments, such as health care or a legal visit. Overall, activity sessions attendance rates were low, particularly for education classes. Prisoners' punctuality at activity sessions was poor.

5.18 Leaders had not prioritised the provision of an appropriate English and mathematics curriculum. In education classes, not enough places were available to help prisoners develop their English and mathematics skills. Prisoners attending workshops and work received no support to improve their English and mathematics levels.

5.19 Leaders had made inadequate progress in introducing an effective prison-wide reading strategy. As a result, prisoners made little headway in improving their reading skills for learning and pleasure. Leaders had been slow in establishing the reading levels of the prison population. An evaluation of reading competence was being undertaken, but there was a substantial backlog. Most teachers had recently participated in appropriate specialist training. Similar development opportunities were not planned for other staff. Unless they attended education classes, most prisoners received insufficient support to promote their reading skills. The Shannon Trust (see Glossary) had trained 10 mentors, but uptake of the help on offer was low. There were no classroom sessions dedicated to reading. The library was closed, so its use in promoting the benefits of reading to prisoners remained unexploited (see also paragraph 5.5).

5.20 Leaders had only recently introduced relevant induction arrangements. As a result, a considerable number of prisoners had not received an appropriate introduction to the ESW offer. This hindered their decision-making as to what activity they could apply for.

5.21 Leaders had identified that they were not providing prisoners with sufficient and effective careers information, advice and guidance (CIAG). Over a third of prisoners had not received CIAG to help them make appropriate decisions about their future. Too often, prisoners' CIAG plans failed to include detailed targets that were subject to routine review and updating.

5.22 Allocation of prisoners to activities normally included an adequate consideration of their prior education attainment. Those who had not participated in CIAG were not guaranteed to be allocated to their preferred activity. Synchronisation of allocations required improvement. For example, prisoners were allotted places in servery teams without completing an appropriate food hygiene course. Sentence plans were not used to inform the allocations process. There were long waiting lists in many areas, but they were managed appropriately.

5.23 Local pay rates did not act as a disincentive to education attendance. Financial bonuses were paid for the achievement of qualifications – for example, in English and mathematics.

5.24 Milton Keynes College delivered education and vocational training in the prison. The curriculum did not reflect the prison's new emphasis on

its training function. It was too narrow and not always planned logically to build on prisoners' prior learning. Regime interruptions were a major contributor to the curtailment of effective lesson planning and delivery. Teachers and trainers often spent much time identifying and dealing with gaps in prisoners' learning because of their long absence from classes, rather than building on prior learning, which slowed prisoners' progress. Many prisoners had been on courses for a considerable period and not achieved their qualification by the planned completion date. Very few achieved qualifications higher than level 1 or moved to the next level of learning.

5.25 Most teachers' and trainers' lesson planning, using the outcomes of assessments of what prisoners already knew and could do, required improvement. Teachers and trainers relied too much on prisoners' self-evaluation of their own prior learning and skills abilities. The accuracy of these assessments was not subject to appropriate checks.

5.26 Teachers, trainers and instructors failed routinely to set prisoners challenging development targets that identified and addressed learning needs or accelerated their employment and personal skills development. Consequently, teachers, trainers and instructors did not plan learning logically to help individual prisoners gain the specific knowledge, skills and behaviour that they needed to achieve further.

5.27 Leaders did not provide specialist support for prisoners who had complex needs or specific learning difficulties and/or disabilities, such as autism spectrum disorder and attention-deficit hyperactivity disorder. Special educational needs provision was not adequately coordinated or available in workshops and work. When prisoners indicated a need, no referral was made to help them to gain the support required.

5.28 Peer mentors in education and workshops were not deployed or managed effectively to support prisoners' learning. Not all mentors were competent to carry out their role. For example, while they supported prisoners with their spelling, mentors made significant mistakes in their own spelling.

5.29 Outreach provision was effective for the few hard-to-reach prisoners on the close supervision and segregation units. However, there was no such provision in vocational training or workshops, or work to help prisoners develop their English and mathematical skills. No opportunities to improve English and mathematics skills, or receive learning support to encourage informal learning, were available to the 23% of prisoners who were unemployed.

5.30 Most teachers and trainers were suitably qualified, skilled in their subjects and had relevant vocational experience. However, they did not receive sufficient or regular training that helped them to improve their teaching practice. Few instructors were trained to coach or teach. They did not participate in a comprehensive training programme to help them become better practitioners in facilitating prisoners' learning.

5.31 The small number of prisoners who persevered with their learning developed new knowledge and skills. They produced work of at least the expected standard. In art, music technology and English, prisoners produced work of a consistently good quality.

5.32 The comparatively few prisoners who completed accredited qualifications achieved them at a high level. The achievement of non-accredited qualifications was high.

5.33 Prisoners displayed a poor attitude towards their learning and development. The limitations of the curriculum, frequent cancellations and subsequent erratic session attendance demotivated prisoners. As a result, they often left their activities earlier than planned or did not value attendance at ESW sessions. In addition, only 20% of respondents to our survey said that staff encouraged them to attend ESW.

5.34 Prisoners behaved well in activity sessions. They treated teachers, trainers, instructors and each other with respect. Staff dealt with the rare instances of inappropriate behaviour effectively. We observed prisoners adhering to health and safety procedures and rules, which were strictly enforced. For example, in the electronic device dismantling workshop, two prisoners were sent back to the accommodation unit as they were not wearing appropriate safety boots.

5.35 Prisoners who attended education, vocational training and workshops engaged well with the set tasks. They worked diligently on individual, pair and group assignments. They had the opportunity to complete paper-based work in their accommodation units. However, they often did not receive timely feedback to help them progress, or appropriate certification following completion. Those allotted accommodation unit work were underemployed and rarely developed an appropriate work ethic.

5.36 Leaders had not established a broad curriculum that allowed prisoners to engage in a range and variety of enrichment activities for enjoyment and learning. Promotion of prisoners' character, including resilience, confidence and mental health, was inadequate. They received insufficient preparation for life in the community. For example, they were not taught how to protect themselves from the dangers posed by radicalisation and extremism. Apart from education classes, activity areas did not develop prisoners' understanding of values of tolerance and respect, or equality and diversity.

5.37 The small number of prisoners released from the establishment were unable to access CIAG support. In addition, they did not receive pertinent pre-release preparation – for example, through participating in training on how to complete CVs, undertake job searches or take part in interview preparation. The virtual campus (see Glossary) was rarely used to make sure that prisoners extended their learning or prepared for the future. No prisoners benefited from employment opportunities outside the prison as part of their entitlement to release on temporary licence.

5.38 Leaders had insufficient oversight of the quality of training in workshops and work. Their collation, analysis and use of data for performance monitoring and decision-making required improvement. They made little use of quantitative targets to check the progress and impact of development initiatives. This contributed to the extremely slow pace of curriculum quality improvement.

# Section 6 Rehabilitation and release planning

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

## Children and families and contact with the outside world

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

6.1 There was satisfactory provision for social visits, but not enough vision and drive behind the work to support family ties. Strategies were out of date and the work needed more impetus.

6.2 The visits team provided a reasonable service and, in our survey, 27% of respondents said that they had been able to see family or friends more than once in the last month, against 16% in comparable prisons. Weekend visits had resumed in January 2023. Social visits sessions had recently increased in length to an hour and a half, although we were told that this was often cut short through slippage in the regime, as happened during the inspection.

6.3 The large visits hall had been refurbished and was bright, although the fixed metal seating was uncomfortable. Only 28 visits could take place at a time, through lack of staffing, rather than space. Some basic snacks and drinks were on sale, and there was supervised play for children at all sessions.

6.4 A regular pattern of well-organised 'father and child' days had been re-established. The Prison Advice and Care Trust team, which had committed and active leadership, provided a good service in the excellent visitors centre and in the visits hall. It also worked with some families in the community and individual prisoners on personal strategies to strengthen family ties. However, this work was limited to five hours a week, and no parenting courses were held beyond the small amount of one-to-one work.

6.5 Secure video calls (see Glossary) had not been possible for many months, other than in emergency situations, because of staffing constraints. This, in addition to several in-cell telephones being out of action, was a serious disadvantage to the many whose families lived far away. The most recent evidence showed 40 in-cell telephones out of action, for a variety of reasons. One prisoner told us that he had had no telephone in his cell for six months, and wing staff confirmed that there had been long waits for repairs. During the inspection, cabling

was installed for five new video-calling booths, positioned so that no extra officer would be needed to supervise them, which would improve the situation.

## Reducing risk, rehabilitation and progression

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

6.6 The prison held an extremely complex population in relation to offender management and public protection. Nearly all prisoners were serving long sentences, including about a third who were serving a life or indeterminate sentence, often for committing violent crimes.

6.7 Leaders should have been prioritising the strategic management of reducing reoffending, but much of this work had lapsed until very recently and had been far too slow to improve. Multidisciplinary meetings had restarted in April 2023. However, not everyone who was required to attend did so, and the meetings did not discuss all the resettlement pathways or have sufficient focus. There was no up-to-date strategy, informed by an analysis of the needs of the population, to determine priorities, and action planning was weak.

6.8 However, the resilience and dedication of staff in the offender management unit (OMU), which had been affected by longstanding staffing shortfalls, were commendable. The OMU was well led, but remained severely short of probation-trained staff, and operational prison offender managers (POMs) were often redeployed to other duties. POM and case administrator caseloads were lower than at the time of the previous inspection, but were still too high, especially given the complexity and risk of the prisoners they were managing.

6.9 In our survey, 75% of respondents who had a custody plan, said that they knew what to do to achieve their targets, but only 27% said that someone was helping them to do this, which was similar to findings at the time of the previous inspection.

6.10 Most prisoners were serving long sentences, so that sequencing of interventions was both inevitable and necessary. However, many were understandably frustrated about the lack of opportunities to demonstrate progression, either through structured risk reduction work or engagement in a fulfilling and purposeful regime (see also section on education, skills and work activities).

6.11 In most instances, contact between POMs and prisoners was still not good enough to address offending behaviour; it was mostly sporadic, driven by timebound tasks such as offender assessment system (OASys) reviews or upcoming parole hearings. In contrast, we saw a few good examples of considered and skilled case management work, with evidence of motivational techniques being used to encourage

hope and progression, challenge poor behaviour and generally build rapport.

6.12 A co-working arrangement remained in place, whereby probation-employed POMs held some of their cases as the named offender manager, but devolved day-to-day case management responsibility to the prison-employed POM working under their supervision. While this continued to help alleviate some of the pressure of high caseloads, many of these high-risk and complex prisoners were not receiving the skilled intervention of a trained probation officer.

6.13 Key work (see Glossary) to support and enhance offender management was non-existent (see also paragraph 4.5). This left the already overstretched POMs carrying out tasks that could otherwise have been undertaken by key workers. The continued delivery of monthly OMU wing-based clinics helped mitigate the situation and was positive and enabled prisoners to see and speak to an offender manager.

6.14 Most prisoners had an initial assessment of their risk and needs (an OASys), and at the time of the inspection about 24 were outstanding. Good efforts were made to keep on top of the small but persistent backlog, including temporary assistance from two community-based probation offender managers.

~~6.15~~ OASys reviews were not always timely, even within the HM Prison and Probation Service timescales, where the expectation was to undertake a review every two to three years, or when there was a significant change in circumstance. Of the cases we looked at in detail, the standard of OASys assessments was reasonably good.

6.16 Sentence plan objectives were mostly relevant and tailored to prisoners' individual needs, which was an improvement since the previous inspection. However, in a few cases, objectives were too generic and did not always specify the work that needed to be done to achieve them.

6.17 Very few prisoners were eligible for home detention curfew because of the length of their sentence. For those that were, arrangements were managed efficiently and releases were timely.

**Public protection**

6.18 Nearly three-quarters of the population was assessed as presenting a high or very high risk of serious harm to others, and most would be subject to multi-agency public protection arrangements (MAPPA) on release because of the nature of their offences.

6.19 Public protection monitoring arrangements were weak. Work to embed new administrative processes had taken place, but more robust governance and recording arrangements were needed to make sure that the screening of new arrivals appropriately identified those who needed to be monitored.

6.20 Far too little telephone monitoring took place to manage specific risks. Only six prisoners had been subject to restrictions on their communications in the last 12 months, and there were none at the time of the inspection. However, when we reviewed previous records where restrictions had been imposed, there had been long delays in calls being listened to (sometimes more than five weeks). In addition, some core monitoring logs were not sufficiently detailed or consistently used, and some reviews that were due were either missing from the record or late.

6.21 The monthly interdepartmental risk management (IDRM) meeting was now better attended and the prison had good oversight of the risk planning arrangements for prisoners due for release, irrespective of their level of risk.

6.22 Joint working and information sharing between POMs and COMs were usually reasonable, but not always timely, despite the OMU's efforts to follow up and escalate issues when there was no reply.

6.23 The quality of risk management plans was mostly good and contained detailed analysis of prisoners' risk, both in a custodial setting and in the community. The prison's written contributions to community MAPPA meetings were useful and usually well informed, but, in the sample we reviewed, information about security and safeguarding had not been fully completed in a couple of instances.

6.24 Prisoners who potentially posed a continuing risk to children were reviewed appropriately, and only a few had an assessed risk level that permitted them contact with a named child. The senior probation officer and staff in the mail room showed good awareness of restrictions and their implications, but these were less well understood by some other staff in the OMU.

**Categorisation and transfers**

6.25 Recategorisation reviews were generally well considered, and decisions were defensible, but they were often delayed because of late contributions, often from security staff, and staffing pressures within the OMU. Prisoners could contribute to their review in writing, but not in person, which was a missed opportunity for face-to-face contact to motivate and support them.

6.26 The prison had transferred 51 category C prisoners in the previous 12 months, and at the time of the inspection it held 49 such prisoners. While some of these individuals were subject to a transfer hold for appropriate reasons, others were keen to progress and were frustrated by the lack of timely movement, mainly because of national population pressures.

6.27 Category A prisoners were reviewed annually and their cases were considered by a local advisory board, chaired by the governor or deputy governor. We examined a category A dossier containing a comprehensive assessment of the prisoner's potential risk of harm and

the work undertaken to address his behaviour. The decision for this individual to remain as a category A prisoner appeared appropriate and justified.

## Interventions

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

6.28 Although there was not a wider needs analysis for reducing reoffending, a comprehensive profile of the potential treatment needs of the population had been undertaken. This included a detailed understanding of most prisoners' risk levels, likelihood of reoffending and suitability for treatment, level of motivation, previous programme completions, offence type and sentence length. This database was continually updated and enabled staff to plan for, and sequence, interventions appropriately.

6.29 The prison offered two accredited offending behaviour programmes – the Thinking Skills Programme (designed to help prisoners develop cognitive skills to manage their risk) and Kaizen (a high-intensity programme, introduced since the previous inspection, for those convicted of violent offences).

6.30 These programmes were appropriate for most of the known needs of the population. However, the treatment needs of some were not known as they were waiting to be assessed and there were gaps for an increasing prevalence of gang-related offending and for some prisoners with learning difficulties.

6.31 Many prisoners could wait a long time before starting an intervention. Managers were prioritising waiting lists and the allocation of prisoners to programmes dynamically, on the basis of national instructions – for example, preference was given to those serving indeterminate sentences who were over tariff, those with upcoming parole hearings and those closest to release.

6.32 A few other lower-level interventions were offered to help prisoners begin considering their attitudes, thinking and behaviour. These included the 'Motivational and Engagement Intervention', which was a validated course, and in-cell packs to address topics such as anger management, conflict resolution and problem solving. Delivery of the chaplaincy-led Sycamore Tree programme (a volunteer-led victim awareness programme) was yet to resume.

6.33 There were 21 prisoners serving indeterminate sentences for public protection. Most were beyond the tariff set when they were sentenced or had been recalled. The on-site forensic and clinical psychology team and OMU were working together to oversee these and other complex prisoners struggling to progress. They undertook regular case reviews and progression panels, and monthly offender personality disorder

'formulation' meetings were a good opportunity to share expertise and troubleshoot individual complex cases.

## 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.

6.34 Although the establishment was not resourced as a resettlement prison, there had been 79 releases into the community in the previous 12 months, which was more than twice as many as in the year before the previous inspection.

6.35 In the absence of any formal resettlement services, release planning relied on POMs and COMs working together. In the cases we examined in detail, practical pre-release planning was thorough and demonstrated good POM/COM liaison and contact with the prisoner. Housing needs had been identified early, and in the previous 12 months all prisoners released had some form of accommodation to go to – a third of them to probation approved premises.

6.36 Prisoners received only basic support with managing their finances. A few had opened bank accounts with the help of OMU staff, and referrals could be made to a Department for Work and Pensions worker based in the community to set up benefits claims on release.

# Section 7 Progress on recommendations from the last full inspection report

## Recommendations from the last full inspection

The following is a summary of the main findings from the last full inspection report and a list of all the recommendations made, organised under the four tests of a healthy prison.

## Leadership

### Key recommendation

There should be clear measures to train, retain and develop operational staff and to increase the confidence, competence and consistency shown by prison officers in their supervision and support of prisoners, with objective assessment of outcomes.

**Not achieved**

## Safety

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

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

### Key recommendations

Behaviour management approaches, including CSIP, should be used by staff at all levels to reduce violence by focusing on the individual prisoner, who should be personally involved.
**Not achieved**

Continued development of data analysis and monitoring should underpin effective work to reduce the rate of self-harm, with all relevant prison staff working in a consistent and coordinated way to support prisoners at risk.
**Partially achieved**

### Recommendations

Staff on the induction unit should ensure that all prisoners are provided with basic services such as phone calls on the first day and access to the canteen in their first few days at the prison.
**Not achieved**

The necessity and proportionality of use of force should be scrutinised in detail, including monitoring of all use of force by a manager and a review of incidents at use of force meetings.
**Not achieved**

Reintegration planning in the segregation unit should restart with a view to reducing the average length of stay.
**Partially achieved**

Prisoners on ACCTs should be consistently supported by wing staff, and daily welfare checks should be entered on their NOMIS records.
**Not achieved**

Outcomes from the quality assurance of ACCTs should be regularly relayed to staff involved in the ACCT process, to promote learning and improvement.
**Not achieved**

## Respect

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

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

### Key recommendations

All residential areas should be kept clean through effective systems of work, monitoring, and access to the necessary materials.
**Not achieved**

Consultation arrangements should identify prisoners' concerns effectively and should result in prompt actions.
**Not achieved**

### Recommendations

Prisoners should be able to access their property within a reasonable timescale.
**Not achieved**

Cell call bells should be answered within five minutes.
**Not achieved**

Prisoners’ views on catering should be acted on to improve catering provision.
**Not achieved**

The number of prisoner applications and response times should be systematically monitored.
**Not achieved**

Complaints monitoring data should be reviewed and analysed thoroughly and lessons learned to reduce the high number of complaints being made.
**Partially achieved**

Data on the treatment of prisoners in protected groups should be analysed, discussed with those groups and acted on to ensure fair outcomes.
**Not achieved**

Patients should have prompt access to health services, including sufficient officer support to ensure safe and timely medication administration and prompt attendance at health clinics.
**Not achieved**

There should be a systematic, prison-wide approach to promoting prisoner well-being guided by a health promotion strategy which is monitored regularly.
**Not achieved**

Patients requiring a transfer under the Mental Health Act should be assessed promptly and transferred within the current transfer guidelines.
**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 recommendation

Opportunities for work and other constructive activity should be extended to more prisoners, so that all have sufficient regular and predictable time out of cell to promote rehabilitation and mental well-being.
**Not achieved**

### Recommendations

Leaders and managers should ensure there is wider participation in education, skills and work from all areas of the prison, including a rapid return to classroom-based teaching.
**Not achieved**

The number of prisoners who complete and return the education induction packs, including the initial assessment, should be increased so that staff can provide support and allocate prisoners to activities more effectively.
**Not achieved**

Leaders and managers should ensure that prisoners with identified learning difficulties or disabilities receive appropriate support so that they can access education.
**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 not sufficiently good against this healthy prison test.

### Key recommendations

Staff resources in the OMU should be sufficient to ensure that all POMs have caseloads which permit effective offender management and regular contact with the prisoners for whom they are responsible.
**Not achieved**

Managers should ensure that public protection monitoring is timely and effective.
**Not achieved**

### Recommendations

Visits and secure video call sessions should be reinstated at the weekends.
**Not achieved**

A comprehensive needs analysis should be used to inform a prison-wide reducing reoffending strategy designed to address the needs of prisoners.
**Not achieved**

All prisoners should have an up-to-date OASys assessment completed within the previous 12 months.
**Not 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:

| | |
|---|---|
| Martin Lomas | Deputy Chief Inspector |
| Sara Pennington | Team leader |
| David Foot | Inspector |
| Martin Kettle | Inspector |
| Steve Oliver-Watts | Inspector |
| Kellie Reeve | Inspector |
| Jade Richards | Inspector |
| Liz Calderbank | Support inspector |
| Helen Downham | Researcher |
| Helen Ranns | Researcher |
| Sam Rasor | Researcher |
| Sarah Goodwin | Lead health and social care inspector |
| Dee Angwin | Health and social care inspector |
| Helen Jackson | Pharmacist |
| Bev Gray | Care Quality Commission inspector |
| Nigel Bragg | 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**
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.

**Close supervision centre**
The close supervision centre system holds about 60 of the most dangerous men in the prison system. Many of these have been imprisoned for very serious offences which have done great harm, and have usually committed subsequent very serious further offences in prison, and their dangerous and disruptive behaviour is too difficult to manage in ordinary prison location. They are held in small units or individual designated cells throughout the high-security prison estate. These men are likely to be held for many years in the most restrictive conditions, with limited stimuli and human contact.

**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.

**NEWS2**
A nationally recognised tool used to monitor deteriorating patients.

**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.

**PAVA**
PAVA (pelargonic acid vanillylamide) spray is classified as a prohibited weapon by section 5(1) (b) of the Firearms Act 1988.

**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).

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

**Shannon Trust**
A national charity which provides peer-mentored reading plan resources and training to prisons.

**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.

**Virtual campus**
Internet access for prisoners to community education, training and employment opportunities.

# Appendix III  Care Quality Commission Requirement Notice

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

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

**Provider**

Central and North West London NHS Foundation Trust

HMP Woodhill

**Location ID**

RV3X2

**Regulated activities**

Treatment of disease, disorder, or injury

Diagnostic and screening procedures.

**Action we have told the provider to take**

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

**Regulation 12 (1)(2)(a and b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

(1) Care and treatment must be provided in a safe way for service users.

(2) Without limiting paragraph (1), the things which a registered person must do to comply with that paragraph include—

(a)assessing the risks to the health and safety of service users of receiving the care or treatment;

(b)doing all that is reasonably practicable to mitigate any such risks;

**How the regulation was not being met**

**Staff had failed to comply with national guidance and/or the trust's policy on Recognition and Management of the Deteriorating Patient.**

We found that two service users were not assessed or treated in accordance with national guidance or the trust's own policy. We found that staff were not always carrying out continued monitoring in line with NEWS2 national and local guidance.

**Regulation 17 (1)(2)(a,b,c and f)**

**17.**—(1) Systems or processes must be established and operated effectively to ensure compliance with the requirements in this Part.

(2) Without limiting paragraph (1), such systems or processes must enable the registered person, in particular, to—

(a)assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b)assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(c)maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;

(f)evaluate and improve their practice in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

How the regulation was not being met

**Staff failed to follow the trust's incident and serious incident policy.**

The trust had failed to report internally a serious incident or inform external bodies of this incident which occurred in June 2022 relating to care provided to a service user during the period of January to June 2022 inclusive. A thorough investigation had not taken place which meant that any shortfalls in care could not be shared and or learned from.

**The trust had failed to ensure service users had an up-to-date risk assessment in place for service users administering their own medication or that staff could access historic risk assessments in full.**

During this inspection, we found that 106 out of 310 patients administering their own medication did not have an up to date in possession risk assessment. Once raised managers put measures in place to address this, however this showed there was a lack of oversight of in-possession risk assessments.

**The trust's policy on substance misuse failed to include sufficient detail around clinical monitoring and observations around patients who had become unwell following use of illicit substances.**

The joint illicit substance misuse guidance between the trust and the prison failed to specify how nursing staff should monitor and/or continue to monitor patients who had become unwell after taking illicit substances, or whether follow-up was required should a patient refuse support.

**The trust's Standard Operating Procedure for the use of Oxehealth (non-contact technology) in the Clinical Assessment Unit (CAU) at HMP Woodhill did not require consent on an individual basis or when a best interest decision should be made.**

During the inspection we identified blanket use of the trust's Oxehealth video monitoring which operated in all cells within the CAU. The guidelines assumed consent for all patients with a cell in the CAU regardless of their individual healthcare needs.

**Regulation 11 (1)(2) (3)(4)(5)**

**11.**—(1) Care and treatment of service users must only be provided with the consent of the relevant person.

(2) Paragraph (1) is subject to paragraphs (3) and (4).

(3) If the service user is 16 or over and is unable to give such consent because they lack capacity to do so, the registered person must act in accordance with the 2005 Act.

(4) But if Part 4 or 4A of the 1983 Act applies to a service user, the registered person must act in accordance with the provisions of that Act.

(5) Nothing in this regulation affects the operation of section 5 of the 2005 Act, as read with section 6 of that Act (acts in connection with care or treatment).

How the regulation was not being met

**Staff failed to seek consent on an individual basis.**

At the time of our inspection 10 of the 12 beds were occupied with patients who had a mixture of needs. These were not always health related. There was blanket use of Oxehealth video monitoring. Staff failed to risk assess patients on an individual basis or make best interest decisions in relation to its use.

# Appendix IV  Further resources

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

## Prison population profile

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

## Prisoner survey methodology and results

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

## Prison staff survey

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

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

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

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