Report on an unannounced inspection of

HMP Bedford

by HM Chief Inspector of Prisons

30 October – 9 November 2023

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Introduction

At the last inspection of this inner-city Victorian jail we reported on improvements after we had previously issued an Urgent Notification in 2019. I am disappointed to report that at this inspection we found that standards had fallen badly: our four healthy prison tests rated the jail as poor for safety, respect and purposeful activity, and not sufficiently good in preparation for release.

The governor, who had been in post since January, had a reasonable understanding of the many challenges facing the jail. She was dealing with some complex personnel issues and as a result, was in the process of rebuilding her leadership team. She was, however, not visible enough around the prison where standards of cleanliness on wings and in cells had worsened considerably since our last inspection. On this visit we found filthy floors and serveries that compounded the overcrowded conditions in which most prisoners were held, while many cells had broken furniture, windows and were covered graffiti.

A new temporary deputy governor had recently arrived and had begun to grip some important areas such as the use of force. We were particularly impressed with the use of body-worn cameras during incidents, which at 90% was among the highest we have seen.

Although on paper the staffing situation at Bedford looked reasonable, too many officers were not available for full duties and levels of long-term sickness were high. Many officers were inexperienced and did not have a clear idea of the role. These shortfalls were affecting the delivery of many of the core services in the prison.

Some of the accommodation in Bedford was the worst I have seen. On E wing, the smell of mould in one cell was overpowering, with the walls damp to the touch, while the underground segregation unit was a disgrace. Here, problems with the drainage mean that on very wet days, raw sewage covered the floor and the cells were dark, damp and dilapidated. Despite this dedicated staff did their best to provide care for what were often very mentally unwell prisoners in wholly unsuitable conditions.

As at the last inspection, prisoners spent too long locked in their cells with not enough to do. For unemployed prisoners on some wings this meant they were unlocked for fewer than two hours a day. The provision of education was even worse than at our last inspection and was now poor. There were not enough places on offer, particularly in English and maths, where there were long waits to join courses. Attendance was much too low at just 52%.

Levels of violence remained very high, particularly assaults on staff which were among the highest in the country. Much of this was the result of the limited time that prisoners had out of cell, and the disastrous applications and complaints systems which meant prisoners found it hard to get questions answered or problems solved. There was virtually no key work being delivered, resulting in

issues that could have been dealt with at officer level often ending up on the desks of senior leaders.

We were particularly concerned about the increase in levels of self-harm and the fragility of the support for the most vulnerable prisoners, particularly given that there had been a serious deterioration in mental health services.

There were often difficulties with booking visits, some of which were cancelled anyway, and the prisoners were offered little opportunity to make video calls. There were plans to make better provision for the large remand population, including the many who were released straight from court. Of ongoing concern at the jail was the 30% of prisoners who were released homeless, making it virtually impossible to break the cycle of mental health difficulties, drug taking, crime and imprisonment. I was disappointed to see that the departure lounge, which we had praised on our last inspection, was no longer operating.

While we left Bedford very concerned about the ongoing problems at the jail, there were many hardworking staff doing their best in difficult conditions. Encouragingly, the governor and the prison group director had no illusions about the challenges that they faced. There will need to be considerable support from the prison service with resource and infrastructure if this neglected prison is to improve and break the cycle of poor inspection reports. In future the governor will need to be more present on the wings overseeing progress and supporting her staff as they embark on what will be a difficult and lengthy transformation.

Charlie Taylor
HM Chief Inspector of Prisons
December 2023

What needs to improve at HMP Bedford

During this inspection we identified 15 key concerns, of which seven 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. **Care for prisoners at risk of self-harm or suicide was weak.** ACCT reviews lacked a multidisciplinary approach and most were ineffective. Mental health referrals were too often overlooked.

2. **Levels of violence, especially against staff, were very high. Much of this was fuelled by prisoner frustration at poor and inconsistent time out of cell and lack of response to legitimate requests through the application and complaints systems.** Leaders did not deliver a full and purposeful regime that motivated prisoners to behave, engage or progress.

3. **Many cells needed refurbishment and/or redecoration, many prisoners were held in mouldy cells, with broken windows and graffiti.** Living conditions in the segregation unit were squalid**.** There was evidence of mould and infestation of rats and cockroaches.

4. **Prisoners, staff and managers reported witnessing racism.** Systems to ensure fair treatment and inclusion were weak.

5. **Mental health services were poor.** The quality and level of support for patients were very limited and did not meet the needs of the population.

6. **Leaders had failed to provide a curriculum that adequately prepared prisoners for employment after release and that benefited vulnerable prisoners.** They did not consider local skill needs. They did not offer opportunities for accredited vocational qualifications, progress or appropriate career pathways, nor did they provide well-equipped training areas.

7. **Leaders did not use education, skills and workplaces efficiently, allocate prisoners appropriately or secure high attendance overall.**

Key concerns

8. **Care and support for prisoners in their early days had deteriorated**. Time out of cell was poor, first night cells were dirty and the induction was not adequately organised or informative.

9. **The amount of force used by staff was high. Scrutiny had not identified all examples of poor practice and excessive force.**

10. **Staff did not develop effective relationships with prisoners.** Key work was not being delivered and prisoners lacked faith in the ability of staff to resolve legitimate concerns.

11. **The out-of-hours medicines cabinet was poorly stocked, contributing to delays in patients receiving medicines**. There was no governance of the use of the cabinet and it contained some out-of-date medicines.

12. **Leaders did not provide sufficient English and mathematics spaces to accommodate the needs of the population.**

13. **Leaders did not provide effective career education information, advice and guidance. Prisoners did not receive the right advice to help them with their next steps or future careers**.

14. **Staffing shortfalls had had a detrimental impact on prisoners' ability to maintain family contact.** Prisoners experienced delays in numbers being added to their phone accounts when they arrived. Visits and secure video call sessions had been cancelled and there were delays in post getting to prisoners.

15. **Too many prisoners were recorded as having been released with no address to go to or to accommodation that was not sustainable.**

About HMP Bedford

Task of the prison/establishment
Category B male local prison with a reception and resettlement function

Certified normal accommodation and operational capacity (see Glossary) as reported by the prison during the inspection
Prisoners held at the time of inspection: 334
Baseline certified normal capacity: 267
In-use certified normal capacity: 229
Operational capacity: 400

Population of the prison
- 63% of the population were on remand or unsentenced.
- Just under a quarter of the population were aged 18 to 25 years.
- 62% of prisoners from black, Asian or minority ethnic background.
- Almost a quarter of the population were foreign national prisoners.

Prison status (public or private) and key providers
Public

Physical health provider: Northamptonshire Healthcare NHS Foundation Trust
Mental health provider: Northamptonshire Healthcare NHS Foundation Trust
Substance misuse treatment provider: Northamptonshire Healthcare NHS Foundation Trust
Dental health provider: Time for Teeth
Prison education framework provider: PeoplePlus
Escort contractor: Serco

Prison group/Department
Bedfordshire, Cambridgeshire and Norfolk

Prison Group Director
Gary Monaghan

Brief history
HMP Bedford is a category B reception and resettlement prison for young adults and adult men. It has stood on its current site in the centre of Bedford since the early 19th century. It was enlarged in 1849 and in the early 1990s a new gate lodge, house block and health care centre were added. It mainly accepts prisoners from the local crown and magistrates' courts.

Short description of residential units
A, and C wings: gallery-style Victorian three-storey landings
B wing: closed for refurbishment
B1 and C1: segregation unit
D wing: three-storey wing used for the first night unit, induction and drug treatment
E wing: two-storey wing housing predominantly young adults (18–25 years)

F wing: Victorian two-storey wing, with gallery landings accommodating vulnerable prisoners
The health centre

Name of governor and date in post
Ali Barker, January 2023 -

Changes of governor since the last inspection
PJ Butler, January 2019 – January 2023

Independent Monitoring Board chair
Vicky Stevenson and Anne McDonald

Date of last inspection
February 2022

Section 1 Summary of key findings

Outcomes for prisoners

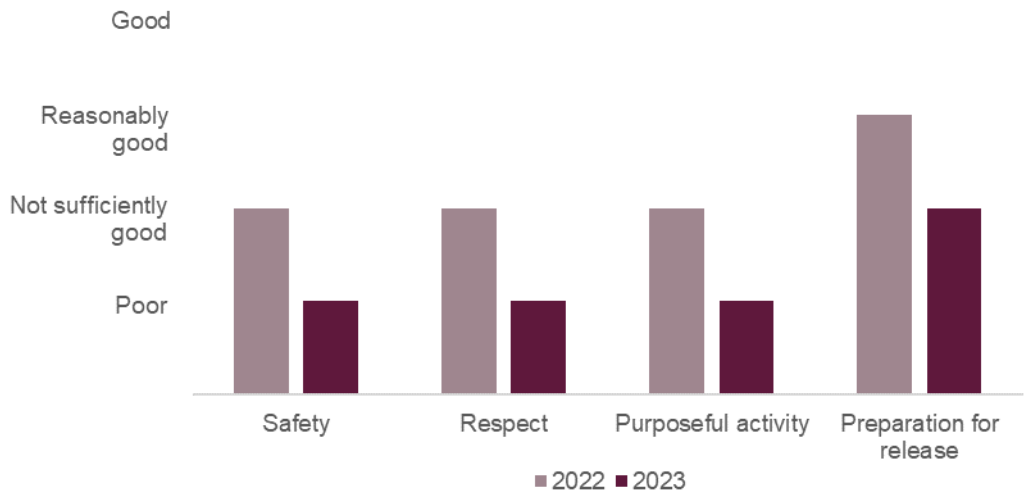
1.1 We assess outcomes for prisoners against four healthy prison tests: safety, respect, purposeful activity, and preparation for release (see Appendix I for more information about the tests). We also include a commentary on leadership in the prison (see Section 2).

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

- poor for safety
- poor for respect
- poor for purposeful activity
- not sufficiently good for preparation for release.

1.3 We last inspected HMP Bedford in 2022. Figure 1 shows how outcomes for prisoners have changed since the last inspection.

Figure 1: HMP Bedford healthy prison outcomes 2022 and 2023



Progress on key concerns and recommendations

1.4 At our last inspection in 2022, we made 38 recommendations, 11 of which were about areas of key concern. The prison fully accepted 36 of the recommendations and partially (or subject to resources) accepted two.

1.5 At this inspection, we found that four of our recommendations about areas of key concern had been achieved, one had been partially achieved and six had not been achieved. All three recommendations made in the area of safety had been achieved. Three recommendations made in the area of respect had not been achieved and one had been partially achieved. Both recommendations made in

purposeful activity had not been achieved. One recommendation made in preparation for release had been achieved and one had not been achieved. For a full list of the progress against the recommendations, please see Section 7.

Notable positive practice

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

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

1.8 Staff were turning on their body-worn video cameras at times when violence was most prevalent in anticipation of an incident. This meant that evidence of the build-up was retained for incidents occurring during that period. (See paragraph 3.32)

Section 2 Leadership

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

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

2.2 The governor had been appointed 11 months before the inspection. On arrival, she had faced several challenges including complaints about members of the senior team and the impact of an escape in 2022. Both she and the prison group director had a clear understanding of most of the significant issues at the site.

2.3 Nine new senior managers had been appointed since the governor arrived, six of them on a temporary basis. It was positive to see the governor taking action to address poor staff performance and other issues, but the scale of leadership changes had created unavoidable delays in improving outcomes for prisoners.

2.4 While the site was fully staffed, high numbers of staff were not available because of sickness, leave, injury or ongoing investigations which meant that leaders were unable to run a consistent daily routine. The regular cancellation of key services, including education, work, visits and religious services, was a cause of understandable frustration among the population.

2.5 In this context, it was appropriate that the governor had prioritised the improvement of leadership culture and staff well-being. Our staff survey indicated the need for further progress in this area: while 44% of all respondents said that the prison was supporting their well-being quite or very well, perceptions among front-line prison officers were notably more negative than other groups.

2.6 Some of the newly appointed leaders were starting to improve systems and processes in areas including preparation for release, violence reduction, oversight of use of force and security. However, most of these improvements had only been put in place in recent weeks and would need to be sustained to have an impact on outcomes for prisoners.

2.7 Several issues that affected outcomes negatively were outside the governor's control. These included the increased population throughput, national leaders procuring an education contract that did not provide cover for teachers' annual leave and considerable delays to the construction of the new segregation unit.

2.8 However, significant deficiencies were within local leaders' control, including the very weak application and complaints systems, insufficient attention to meeting diverse needs, staff not challenging low-level poor behaviour and very low standards of cleanliness on residential units. Support and oversight for the most vulnerable prisoners, including those with poor mental health and at risk of self-harm, were also weak.

2.9 Leaders had not done enough to improve the regime which had rarely been fully operational during the previous two months. This was exacerbated by the weak system for allocating prisoners to education, training and work which led to very high rates of unemployment among the population.

2.10 Despite very recent progress, leaders had not addressed the many legitimate frustrations of prisoners who spent much of their time locked up in squalid cells with nothing purposeful to do. Many were unable to get any response to legitimate requests and became very frustrated as a result. This was a key factor in much of the violence and use of force at the establishment.

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 Approximately 30 new prisoners arrived each week. All prisoners were strip-searched and body scanned on arrival. In our survey, 79% said they were searched in a respectful way. Reception processes identified immediate safeguarding concerns and all prisoners could speak to a nurse in private. A Listener (prisoners trained by the Samaritans to provide emotional support to other prisoners) was available in reception and a hot meal was provided. The freezer used to store meals was dirty.

3.2 Reception interview rooms were shabby and dilapidated. The overall environment was unwelcoming and there was little information for prisoners to read while they waited their turn to speak to a first night officer or nurse.

3.3 D4 was the designated induction landing and overflow wing for prisoners who were vulnerable to assault because of the nature of their offence. At the time of our inspection, 17 prisoners were waiting for a space on F wing which limited the availability of cells for new arrivals, some of whom were taken to other wings on their first night in custody. Wing staff on D4 had the challenging task of managing two distinct regimes to keep vulnerable prisoners separated from new prisoners. All prisoners on D4 received about 45 minutes out of their cells each day, which was unacceptable.

Induction wing

3.4 The D4 landing was dirty, the showers were damp and mouldy and the induction room had not been cleaned for a while. In our survey, only 37% of prisoners said their cell was clean on the first night and we found that most cells prepared for new arrivals were dirty and covered in graffiti. Many prisoners we spoke to complained of dirty cells, lack of privacy curtains and limited access to cleaning materials.

The back of a typical cell door on the induction wing

3.5 Care and support for prisoners during the first few days of arrival had deteriorated since the last inspection. In our survey, 19% of prisoners said they had been helped with problems, 50% had received toiletries and basic items on their first night and 45% had received a free phone call. This compared with 35%, 69% and 61% respectively at our previous inspection. Only 30% said they had showered on their first night.

3.6 The pin phone system remained in disarray. Prisoners were understandably very frustrated at waiting too long to be able to contact their families. In our survey, 57% of prisoners said they had problems contacting their family when they first arrived.

3.7 The issue of a grocery pack to all prisoners during their first few days was inconsistent and some prisoners said they had got into debt because they had not received it.

3.8 In our survey, just 66% of prisoners said they had received induction but only 37% of these said it covered everything they needed to know. Our findings supported this view. The induction presentation was delivered by a prisoner peer worker, but not to all new arrivals. Those who spent their first night on a wing other than D4 were less likely to receive an induction. Induction records were rarely completed by staff and it was impossible for managers to determine if all prisoners had received an induction or other entitlements during their first few days.

Promoting positive behaviour

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

Encouraging positive behaviour

3.9 Levels of violence were very high compared to similar prisons. Bedford had the fifth highest rate of assaults between prisoners (396 assaults per 1,000 prisoners). Assaults against staff were even higher and were ranked as the highest of any adult male prison in England and Wales (410 per 1,000 prisoners). The number of serious assaults, however, had reduced by 18% over the past year.

3.10 In our survey, 53% of prisoners said that they had felt unsafe at some point at Bedford and a quarter said they felt unsafe at the time of the inspection.

3.11 Leaders had appropriately identified this as an area of concern and a new functional head position responsible for violence reduction had been filled very recently. The new head of violence reduction had taken sensible early steps to analyse recent violence in depth and had started to produce a strategy and action plan for violence reduction.

3.12 The analysis showed that nearly half the assaults on staff happened during restraints. The largest proportion of restraints occurred because of prisoners' non-compliance and frustration with an inconsistent regime, lack of constructive activity (see paragraph 5.2) and their inability to get basic day-to-day things done (see paragraph 4.2).

3.13 Care, support and interventions plan (CSIPs, see Glossary) were used to monitor both perpetrators and victims of violence. At the time of the inspection, 18 CSIPs were open, all of which were for perpetrators. The quality of these documents varied because a shortage of work and education to engage prisoners limited the actions that case managers could take. A single case management model had been introduced which gave a manager from the prisoner's wing responsibility for investigating the reason for the violence, completing a CSIP if required and following through all actions. At the time of the inspection, every incident of violence was being investigated, which was positive.

3.14 Staff were aware of CSIPs and their purpose and the staff we spoke to knew which prisoners were on a CSIP and made regular entries about their behaviour. This was good and showed that the system was becoming embedded.

3.15 The violence reduction action plan contained some good innovative ideas that were already being progressed: funding for a prison officer to assist in reducing violence had been secured through a joint initiative with the Police and Crime Commissioner; a new hot spot strategy had started for key staff members to meet every day to make sure that actions from the previous day's incidents had been implemented; and violence reduction peer workers had very recently been re-introduced. Leaders were about to restart the 'leave it at the gate' course for younger adults in an attempt to reduce gang-related violence.

3.16 A good range of data were reviewed at a monthly strategic safety meeting, but attendance was poor at some, few meaningful actions were generated and those that were took too long to complete. The management of prisoners identified as the most violent and those in crisis were discussed at the weekly safety intervention meeting which had better attendance. However, too many prisoners were discussed, which meant that meetings became rushed and lost focus on making sure that prisoners were being actively managed.

3.17 The local incentives scheme had recently been rewritten. Prisoners who engaged were given more money and extra visits under the scheme, but prisoners told us that it did not provide an incentive to behave. Behaviour management was undermined by a lack of challenge of everyday poor behaviour, such as vaping in communal areas, inappropriate standards of dress and swearing.

3.18 The active citizenship scheme which we identified as notable positive practice at our last inspection had stopped because of staffing difficulties, which was disappointing.

Adjudications

3.19 During the previous 12 months, there had been 2,271 adjudications. There were no significant backlogs and improved links with the Police had reduced the time taken for responses to referrals for external investigation.

3.20 In the sample that we reviewed, we found far too many adjudications for offences that could have been dealt with more effectively by wing staff, such as refusing an instruction or possessing an unauthorised item. The quality of enquiry into each charge was inconsistent and there were some very poor examples in our sample. This had been identified by the deputy governor who had recently started to quality assure five adjudications each month.

3.21 A segregation monitoring and review group met each quarter to review the tariff of awards for each charge as well as the adjudication process and to investigate any trends such as prisoners refusing to attend. Suitable actions to resolve any issues were agreed and tracked by the group.

Use of force

3.22 The amount of force used by staff against prisoners was similar to our last inspection. There had been 452 spontaneous uses of force in response to incidents and 61 planned interventions over the previous year.

3.23 Over the same period, batons had been drawn five times and used twice and PAVA (incapacitant spray) had not been used at all, this represented a reduction in previous use.

3.24 We had concerns over the justification for use of force in some of the sample that we viewed. In one instance a prisoner had been struck twice with a baton while self-harming but posing no threat to staff. In another a prisoner was held by staff because he had not consented to a medical procedure and was resisting. The paper records of this incident contradicted the events recorded on body-worn camera footage.

3.25 We also saw camera footage of staff swearing at prisoners during incidents and on one occasion, following a relocation into a cell, an officer went back to confront a prisoner once the instruction to withdraw had been given.

3.26 Leaders had identified some of these incidents and had taken action at the time. Appropriate action was taken at the time of the inspection in the other examples that we highlighted.

3.27 We also observed some better practice with staff trying to de-escalate situations. Most relocations that we observed were passive with the prisoner walking into their cell with a guiding hold.

3.28 There had not been enough scrutiny of the use of force for some time, with only a small selection of incidents viewed at the monthly meetings. This had improved very recently and the deputy governor, head of violence reduction and use of force co-ordinator now viewed 100% of incidents each week.

3.29 Leaders had also stopped redeploying the use of force co-ordinator so that scrutiny could be improved and more debriefs of prisoners conducted following restraint. However, in our survey just 19% of prisoners said that someone came and spoke to them after a restraint.

3.30 A good range of data were reviewed at the monthly use of force meetings and leaders were aware of the reasons for force being used. Suitable actions were generated and staff training was kept up to date in areas such as SPEAR (personal protection training) and PAVA. The actions were focused on the quality of oversight of the use of force, which was important, but no actions were generated to reduce the amount of force being used, which was an oversight.

3.31 Body-worn video cameras (BWVCs) were used well. Bedford was taking part in a trial where the staff member pre-recorded and retained 30 seconds of footage to help capture the run-up to incidents, which was a good initiative. Together with the introduction of new cameras, this had led to more than 90% of incidents being recorded over the previous two months, which was higher than we usually see.

3.32 It was also encouraging to see that staff were turning on their BWVCs at times when violence was most prevalent, such as the serving of meals and movement of prisoners to work, in anticipation of any incident. This meant that evidence of the build-up was retained for incidents occurring during that period, which was good practice.

3.33 The oversight of special accommodation had improved since our last inspection. The special cell had been used once during the previous 12 months and records showed that this had been justified and appropriate in the circumstances.

Segregation

3.34 The accommodation in the segregation unit was unfit for purpose. The unit consisted of two underground landings, one of which was flooded with sewage after periods of heavy rain. Sandbags and wellington boots were stored on the unit to help staff stem the tide and prisoners regularly had to be moved temporarily to other cells.

Sandbags in the segregation unit

3.35 The condition of all the cells was poor. Most contained stained toilets with no seats and damp was a problem in some. Furniture was sparse and most of it was broken and some cells smelt of human effluent despite being cleaned. The communal areas on the unit were austere and cramped, although cleaner than most of the main wings.

Segregation cell

3.36 The unit had been scheduled to close to be replaced with new accommodation, but this had been subject to several delays which had held the project back for more than a year. Leaders hoped that the new unit would be open in March 2024.

3.37 The number of prisoners segregated was similar to the last inspection. During the previous 12 months, 278 prisoners had been segregated on the unit for an average of 11 days. Eleven had been held for more than 42 days, one for more than 84 days and another for more than 126 days.

3.38 Oversight of the unit was good. The reason for every segregation was justifiable and the authority and medical safety screening took place on arrival and at each subsequent review. Prisoners were seen by the duty governor, health care staff and the chaplain each day.

3.39 The leaders and staff on the unit had developed very good relationships with the prisoners and we observed some caring interactions. Prisoners spoke highly of the staff and told us they were helpful and professional. This was reflected in our survey where 85% of prisoners told us they were treated well by segregation unit staff compared with 55% at similar prisons.

3.40 Time out of cell on the unit was limited. Prisoners could consistently expect a shower and time on the exercise yard each day and, in our survey, 95% of prisoners who had been segregated told us they could shower each day against 60% in comparable prisons. Similarly, 91% compared with 63% said they went outside for exercise every day.

3.41 Staff allowed prisoners to exercise together. They had telephones in their cells and, following a risk assessment, a television. Education staff brought distraction packs and did outreach work with prisoners who were segregated for longer periods. We met one prisoner who was proud to show us the reading and writing certificates that he had gained during his stay.

3.42 Efforts were made to reintegrate prisoners on to the main units. We observed innovative initiatives by leaders and staff to promote this, for example one prisoner who had consistently found it hard to cope on the main units and had destroyed his cell was painting other cells on the main wings, gradually allowing him to settle.

3.43 The psychology team helped with reintegration planning by delivering one-to-one work such as helping prisoners to develop emotional management skills, engage with clinical psychology and health care, and prepare for sentence planning targets such as offending behaviour programmes. The team had also supported prisoners with concerns about their resettlement needs and provided help after release in the community.

3.44 One-page plans had been developed for prisoners with complex needs whom staff needed support to manage. These were well embedded and staff were familiar with them and the various triggers for each individual's behaviour, which was good.

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 misuse and effective drug supply reduction measures are in place.

3.45 Since the last inspection, there had been several serious concerns about the security of the prison. There had been an escape from inside the prison perimeter in July 2022 and some key systems and strategies had fallen into disarray. A recent audit by the HMPPS security team had rated the prison's security systems as unsatisfactory.

3.46 A new head of department had been appointed to stabilise the situation and an action plan to rectify the weaknesses in procedural security identified by the escape had largely been completed.

3.47 We found that security systems were proportionate to the security threat of the population.

3.48 A backlog of 686 intelligence reports had been successfully addressed and, at the time of the inspection, there was no backlog. A new intelligence manager had been appointed and all reports were now assessed appropriately and responded to on the same day.

3.49 The local security strategy had been deleted and replaced with an inappropriate strategy from another prison which hindered leaders' attempts to keep Bedford safe and secure. The strategy was being rewritten at the time of the inspection but was still not available to staff.

3.50 A comprehensive local tactical assessment was drawn up each month which analysed the key threats to the prison. This had understandably focused on escape for some time but had recently concentrated on violence.

3.51 Leaders had worked hard to rebuild relationships with partner agencies such as the police and regional search teams. This was beginning to bear fruit with the region providing regular support to carry out searches and the use of drug detection dogs. Police intelligence officers had also assisted prison staff.

3.52 Strategic supply reduction work had stalled while new leaders had come into post, there had been no drug strategy meetings for three months and a new strategy was being written. Staff shortages had prevented mandatory and suspicion drug testing from taking place and leaders were unaware of the scale of any illicit drug economy operating in the prison.

3.53 In our survey, 25% of prisoners told us that illicit drugs were easy to get which was similar to other reception prisons and our last inspection. Leaders had recently identified drones as a new method of supply and were taking steps to counter this threat.

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

3.54 There had been one self-inflicted death and 533 incidents of self-harm during the last 12 months. Rates of self-harm had increased by 84% since the last inspection and were among the highest in the male prison estate.

3.55 An overview of the circumstances of the death in custody had been conducted by the regional safety lead, but prison leaders had not used it to inform the death in custody action plan, which had not been reviewed in the last year. The failure to take learning opportunities from

incidents of suicide and self-harm, from within the prison and across other institutions, was troubling.

3.56 Six incidents of self-harm during the previous 12 months had required hospital treatment and had been recorded as serious. Investigations into serious self-harm were not routinely conducted, leaving leaders in ignorance of the underlying issues and limiting their ability to apply lessons learned to prevent future occurrences.

3.57 During the previous 12 months, 52 prisoners had been on constant watch, but observation monitoring logs were not routinely conducted. Constant watch cells were dreary: one cell in health care was out of action and the other on A wing did not have a mattress. At the time of our inspection, a prisoner had been taken off constant watch by a manager with no authority to do so.

Constant watch cell

3.58 During the previous 12 months, 220 ACCTs (assessment, care in custody and teamwork case management of prisoners at risk of suicide and self-harm) had been opened. At the time of our inspection, nine prisoners were being supported through the ACCT process, one of whom was in the segregation unit. Eight per cent of all self-harm had taken place in the segregation unit, a known high-risk area in all prisons because of the limited time out of cell and interaction with other prisoners and staff, and there was no plan to address this, which was worrying.

3.59 In our survey, only 41% of prisoners who had been supported through ACCTs said they had felt cared for. Too many ACCT reviews lacked a multidisciplinary approach, with a noticeable absence of nurses at many of these. Care plans were frequently incomplete and issues

raised by prisoners in discussion with managers were not consistently translated into tangible steps to help them. This was compounded by a poor mental health service which was not meeting the needs of prisoners (see paragraphs 4.60-4.69).

3.60 ACCT reviews were frequently perceived as unproductive by some prisoners. This was compounded by reviews often being conducted by different managers which made it more difficult to establish trust.

3.61 Attendance by leaders at the monthly safety meetings was inconsistent. Discussions about data did not always result in meaningful actions to address the high rates of self-harm. Notably, the September 2023 meeting had had outstanding actions dating back as far as February, indicating a lack of timely follow-up. In addition, key leaders frequently failed to attend the weekly safety intervention meeting, which resulted in limited oversight and rendered the meeting ineffective in addressing emerging safety concerns.

3.62 Only 23% of prisoners in our survey said that it was easy to speak to a Listener. The scheme had not been adequately promoted, many staff had limited knowledge of it, and Listeners said they had received no requests for support since the recent revival of the scheme. This was inexplicable in a prison with such high levels of need.

Protection of adults at risk (see Glossary)

3.63 A recently revised safeguarding policy did not contain the name of the prison safeguarding lead and there was a notable absence of signage to identify the safeguarding lead and how to contact them. Many staff we spoke to expressed uncertainty about the procedure for making a local safeguarding referral or to whom to send it.

3.64 Prison leaders had established positive connections with the local adult safeguarding board and the governor had attended community meetings. During the previous 12 months, two safeguarding referrals had been initiated.

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 prisoners said that staff treated them with respect. The interactions that we observed were polite but mostly transactional to support the delivery of the regime. The limited time that prisoners were unlocked hindered opportunities to build relationships.

4.2 Prisoners we spoke to described staff as unreliable, failing to help them with daily problems and legitimate requests, such as speaking to other departments on their behalf. This caused frustration and a sense of hopelessness, especially as many prisoners also had a lack of faith in the application system to resolve issues (see paragraph 4.18).

4.3 Leaders had ceased the key worker scheme (see Glossary) and substituted it with a telephone call. This was inappropriate because most prisoners were sharing cells and could not speak in confidence. In the cases that we reviewed, contact levels and quality were poor and many prisoners had been at the establishment for several months with no contact. This was a missed opportunity to build meaningful relationships and ease frustration.

4.4 The use of peer work was underdeveloped. Appointments had only recently been made for roles including safety and equality representatives.

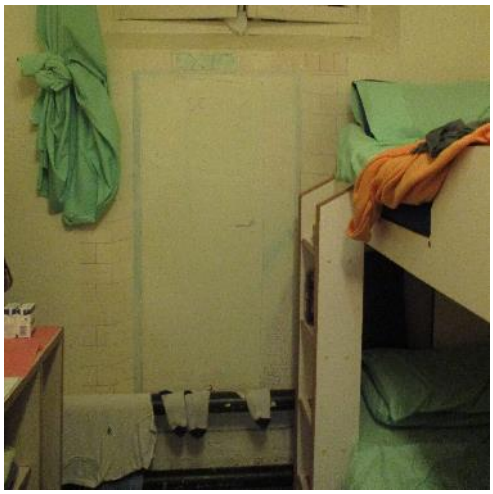
Daily life

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

Living conditions

4.5 There was considerable overcrowding, with almost three-quarters of the population living in cells that accommodated more prisoners than they were designed for. Several cells held groups of three prisoners, and, while these cells were slightly bigger, they were still too cramped for this number of prisoners.

4.6 The condition of cells varied, but too many were in poor condition and some were not fit for purpose with mould and broken windows. At the time of the inspection, more than 100 repair jobs were outstanding and not all work that was needed had been reported. Extensive graffiti in cells across the prison went unchallenged by staff and leaders. A programme to paint and decorate cells was often not operating because of staff shortages. There had been poor oversight of living conditions which leaders had tried during November 2023 to remedy with a tracking document.

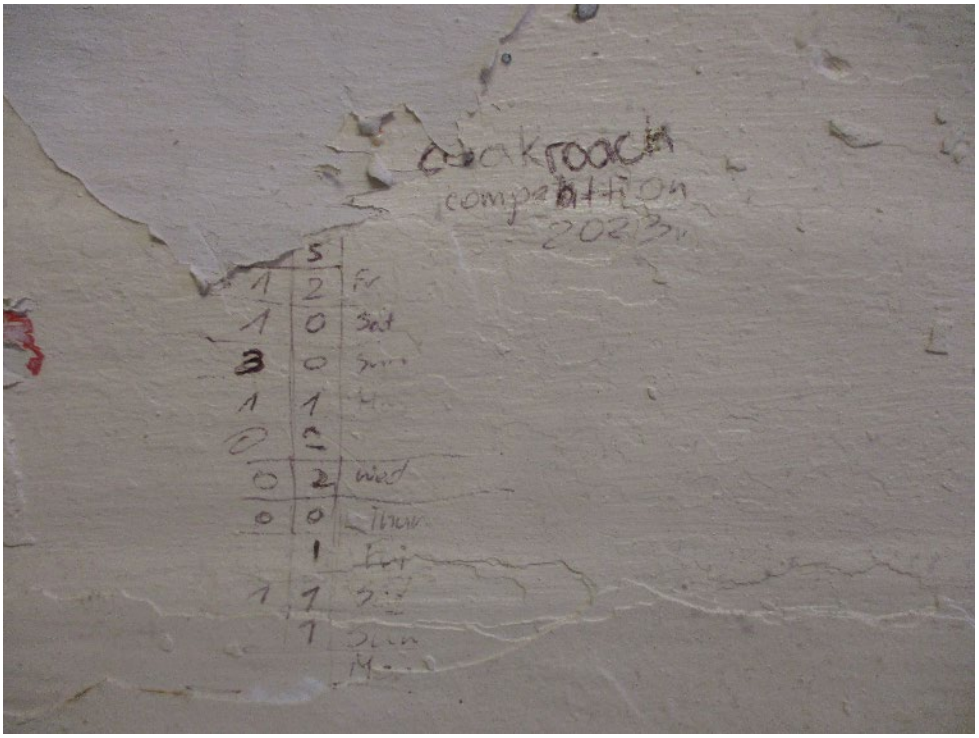


Cells

4.7 Leaders and staff had not set and maintained sufficiently high standards of cleanliness. The wings were dirty and, in our survey, only 42% of prisoners said the communal areas were normally clean, compared with 70% at our last inspection and 66% at similar prisons. Our observations corroborated this. The frequent curtailments to the

regime (see paragraph 5.3) and ineffective use of available staff resulted in too few cleaners being unlocked to clean.

4.8 There was a widespread infestation of rats, cockroaches and pigeons. Professional pest control services had been engaged and outside areas were reasonably clean. However, the unhygienic conditions on the residential wings and the difficulty of treating the residential areas meant that prisoners regularly saw vermin and had resorted to creating their own barriers to prevent vermin from coming into their cells.



Cockroach competition

4.9 In our survey, 84% of prisoners said they could shower each day compared with 64% at the last inspection. Several showers had been damaged with smashed tiles and broken stall doors.

4.10 Access to property was a concern for prisoners. In our survey, only 7% of prisoners said that they could access their stored property, which was very low. The failure of the application system (see paragraph 4.18) resulted in prisoners struggling to get access to their property.

4.11 The use of cell call bells was high, with more than 5,000 each week, as prisoners who spent limited time unlocked attempted to get answers to queries. Leaders used data well to monitor and identify trends, for example increased use of call bells after canteen had been issued. About a quarter were not responded to in a timely manner.

Residential services

4.12 The quality of food was reasonable. In our survey, 43% of prisoners said the food was good, but just 33% said they usually got enough to eat. Leaders had moved the hot meal to the evening, which was

welcomed by prisoners, but the breakfast packs were too small and were served with the lunchtime meal the day before.

Evening meal

4.13 The menu cycle had recently been extended to five choices to meet a range of dietary needs and allergies. Food had been organised for celebratory events, including Black History Month and family days.

4.14 The regime prevented prisoners from eating together and they ate all their meals in their cells. Meals were served in a controlled manner and only a few prisoners at a time were allowed to collect their meals.

4.15 The main prison kitchen was very clean in contrast to the wing serveries, which were dirty with food stored on the floor.

4.16 A reasonable range of items were available through the prison shop, but many prisoners were unemployed and struggled to buy the items they needed. There had been a high number of complaints about the canteen during the last six months, mainly because of missing items and requests for a refund. Leaders had held meetings with the canteen provider to improve the service.

Prisoner consultation, applications and redress

4.17 Prisoners expressed real frustration at their inability to get anything done, for example accessing their property, applying for a job and adding their families' numbers to their phones. This was a key factor in the very high levels of violence and use of force. The application and complaints systems were in disarray.

4.18 The application scheme was convoluted and inadequate and only 27% of prisoners in our survey said that applications were responded to fairly. Prisoners we spoke to were extremely frustrated with the system: forms were not available on all the units and prisoners had to find a member of staff to obtain a form. Not all applications were tracked and just under half of those that were, were responded to late. In the sample that we reviewed, we found prisoners needing a time-critical response, for example asking for clothes for court and not receiving an answer for weeks. This was wholly inappropriate.

4.19 Prisoners frustrated by the application system often resorted to making a complaint. Just under 1,500 had been made in the last 12 months which was the highest rate of all reception prisons. More than a third of complaints were responded to late. In our survey, only 14% of prisoners said that complaints were dealt with fairly. In the sample that we reviewed, there was little evidence of prisoners being spoken to during investigations and some responses failed to address all the issues raised. On occasion, prisoners were re-routed back to the flawed application system.

4.20 Consultation that did take place did not result in issues being addressed. Too few meaningful actions were generated and those that were took too long to complete.

4.21 Facilities for legal visits were adequate, including via video link and in person. A bail information officer provided support to remand prisoners, which was positive. The library offered a range of legal reference books. In our survey, 71% of prisoners said that their legal mail was opened when they were not present, compared with 54% in similar prisons. During the previous 12 months, only eight letters had been recorded as opened in error, but we observed legal mail being delivered partially opened.

Fair treatment and inclusion

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), or those who may be at risk of discrimination or unequal treatment, 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.

4.22 The focus on promoting fair treatment and inclusion had deteriorated during the year. However, an interim manager had been appointed shortly before our inspection and there were plans to recruit two new managers, although they would not be in post until January 2024.

4.23 Compliance checks by the regional equality lead had resulted in low scores but this had not been addressed.

4.24 Many prisoners, staff and managers reported witnessing direct and indirect racism by staff, and many were hesitant to raise complaints. During the previous 12 months, 104 discrimination incident report forms (DIRFs) had been submitted, 40% of which were replied to late and many failed to address the concerns raised. This had also been identified by the Zahid Mubarek Trust which carried out quality assurance of DIRFs.

4.25 About 60% of prisoners were from black or minority ethnic backgrounds, a third of whom were Muslim. There was little provision to identify and address their needs. There were no plans to identify and support the needs of gay and bisexual prisoners.

4.26 Support for other groups was better, notably for transgender prisoners. Planned intervention work to support young adults was frequently cancelled because of staff shortfalls. Prisoners with physical disabilities received good support in health care, but there was no oversight of prisoners with specific needs on other wings. A neurodiversity manager had recently been appointed but it was too soon to assess the impact.

4.27 Only three equality meetings had taken place during the last 12 months. Out-of-date data were reviewed at the meetings and no meaningful actions were taken.

4.28 Equality peer workers had been appointed a week before our inspection. Consultation with prisoners with protected characteristics had ceased with the exception of foreign nationals and care leavers. Consultation had continued with these two groups and useful information had been gathered, but this had not translated into a comprehensive equality action plan.

Faith and religion

4.29 Faith provision was reasonable, but chaplains struggled to see prisoners face to face and often had to conduct conversations through cell doors which was not conducive to building trust. Attendance at Friday prayers was prompt and timely, but the Roman Catholic and Church of England services often started about 45 minutes late and there was regular confusion about which prisoners could attend.

Health, well-being and social care

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

4.30 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).

Strategy, clinical governance and partnerships

4.31 NHS England (NHSE) had awarded Northamptonshire Healthcare NHS Foundation Trust (NHFT) the main health care contract from April 2023 with Central and North-west London NHS Foundation Trust (CNWL) subcontracted to deliver pharmacy services.

4.32 This contractual arrangement had caused considerable disruption, particularly with the management of medicines which had affected the continuity of care and gaps in patients receiving their medication. This had only very recently started to settle.

4.33 Regular partnership board meetings provided strategic oversight. NHSE held regular contract review meetings and their most recent quality review visit had highlighted some concerns.

4.34 Monthly local clinical governance meetings had restarted following a gap of three months when different forums had been used to manage known risks.

4.35 The head of health care had implemented positive changes during a challenging time with a focus on recruitment, where there had been some success, and improving governance. However, staff remained stretched for a number of reasons including vacant posts, long-term sickness and restricted duties. Managers and staff had covered clinical shifts to maintain the service.

4.36 Appointment slips were collected each day and triaged by a registered nurse who booked the appointments. However, patients were not informed of when the appointment had been booked causing frustration and further applications. This had recently been raised at the patients' forum and was being addressed by the head of health care.

4.37 The reporting of clinical incidents and complaints had improved since the last inspection, including the analysis of trends to improve the service. However, we found a serious issue which had not been reported, which was very concerning. When we highlighted this, appropriate action was taken and an investigation was started.

4.38 The daily handover meetings had a set agenda and were minuted, which the head of health care had implemented together with a more robust checking system to make sure that the contents of emergency bags were in date and in good working order. Emergency equipment was strategically placed across the prison and appropriately trained nurses responded to any medical emergency over a 24-hour period.

4.39 Health staff were supported through annual appraisal, managerial and clinical supervision. Compliance with mandatory training was reasonably good and professional development opportunities were encouraged with good uptake to address some of the deficits in the skill mix of the service.

4.40 Some progress had been made on the health recommendations from the Prisons and Probation Ombudsman death in custody reports,

particularly with the use of NEWS2 (the National Early Warning Score, a system to identify acutely ill patients). This was now embedded in practice but attendance and contributions to ACCT reviews (assessment, care in custody and teamwork case management of prisoners at risk of suicide and self-harm) were not good enough.

4.41 There was a confidential health care complaint process and each was investigated and answered with an appropriate outcome. The response indicated how to escalate the complaint if the prisoner was dissatisfied with the response.

4.42 The clinic areas in the health care department were clean and met infection prevention and control standards, but the offices had worn-out carpets and there was no sink in the clinical room of the in-patient unit. Areas for improvement had been escalated to the prison for resolution but had not received prompt attention.

4.43 All services used SystmOne (the electronic clinical record). Records that we reviewed varied from adequate to comprehensive. Standards of record keeping were discussed in supervision sessions, but a more rigorous approach was needed to ensure a consistently good standard.

Promoting health and well-being

4.44 There was no prison-led approach to health promotion but the recently appointed health and well-being coach employed by NHFT had already implemented some positive initiatives, including working with the catering staff on healthy menu options and food allergies.

4.45 The service followed national calendar events, for example ‘Movember’ to highlight men’s health issues. These were reflected with eye-catching displays on health promotion boards on each wing and in health care. A good range of health promotion information was available in other languages and there was some ‘easy read’ material. Telephone interpreting services were used for health appointments when needed, although there was no telephone in one of the health rooms in reception.

4.46 A range of prevention screening programmes were offered, including for bowel cancer. An established smoking cessation clinic continued to run and effective support was offered.

4.47 The new sexual health and blood-borne virus lead was addressing the backlog of screening and hepatitis B vaccinations and had good links with local sexual health services and the Hepatitis C Trust which attended the prison each week. A hepatitis C peer mentor was now in place and there were plans to recruit health champions. Barrier protection was available from health staff.

4.48 There had been delays in starting the flu and COVID vaccination programme, but this was scheduled for delivery imminently.

Primary care and inpatient services

4.49 All new arrivals received an initial health screening on reception by a registered nurse. The screenings that we reviewed identified individual needs and referrals were made where appropriate. There was access to a GP, sometimes by virtual consultation using Visionable (a video consulting tool), or a non-medical prescriber and a substance misuse nurse.

4.50 Secondary health screening had not been carried out within seven days in accordance with NICE guidelines (the National Institute for Health and Care Excellence), but this was now completed promptly.

4.51 There was an adequate range of primary care services with reasonable waiting times for most, including 2.5 weeks to see a GP for a routine appointment. Urgent appointments could also be arranged on the same day. The waiting time for the optician was too long with the longest wait of 13 weeks. This waiting time was increasing because of delays in repairing the clinic room, which was out of action at the time of the inspection following a flood.

4.52 Patients with long-term conditions (LTCs) were identified during reception screening. Their care was largely provided by the GP, although there were some nurse-led clinics and liaison with community specialists when needed. A diabetic clinic was led by a nurse with additional training who delivered good care. The service had identified a skills deficit in the management of LTCs and had scheduled additional training for staff. LTC registers were not used to identify the prevailing need more easily.

4.53 Several blood clinics had been cancelled because there were staff vacancies and no escort officers, but these were now running more effectively. Newly recruited health care assistants had received or were about to receive training which would ease the situation.

4.54 Some external hospital visits had been rearranged for a number of reasons, sometimes by the hospital and sometimes by the prison. This was being monitored and well managed.

4.55 The 11-bed in-patient unit was used for patients with physical and mental health needs. A registered nurse was on duty 24 hours a day. We observed caring and friendly interactions between patients and health staff and all patients had personalised care plans. However, the regime was very restricted with only two hours out of cell a day and limited therapeutic activities to support well-being.

4.56 The officers on the unit were not regularly rostered to work there which led to inconsistency in approach.

Social care

4.57 A memorandum of understanding between the prison, the health care provider and local authority described the responsibilities for prisoners with social care needs and was well embedded. A single point of

referral was managed by the health care team, who were also responsible for delivering care packages (see Glossary). No prisoners required such support at the time of the inspection and we found no evidence of unmet need.

4.58 Local authority social workers undertook all assessments and had good ties to the prison. Referrals were completed face to face in a timely fashion with the outcomes fully documented. However, it was not uncommon for prisoners to have moved before an assessment had been completed, in which case an urgent virtual assessment could be requested if these circumstances were foreseen.

4.59 Effective communication and partnership working were evident, with clear written guidance for staff and prisoners widely displayed and regular formal meetings to share information and discuss activity. Many referrals did not lead to a requirement for care and there was scope to enhance understanding of the Care Act among prison staff.

Mental health

4.60 Mental health services were not meeting the needs of the patients.

4.61 The mental health team included one lead nurse, three mental health nurses, a social worker, a psychiatrist, a psychologist and an assistant psychologist. The team was adequately staffed and consistent agency staff covered vacancies.

4.62 The service had an evidence-based model of care, although in practice the delivery of mental health care did not reflect this model. Staff we spoke to were unable to describe the model or how the care that they delivered reflected its principles. This resulted in patients receiving inconsistent care.

4.63 Case loads were low with 22 patients receiving care from the team and the care programme approach being used to support one patient. Although referrals were reviewed in good time, we saw evidence that some patients' needs were not met, for example a prisoner had recently self-harmed and described previous traumatic events but was not offered any support from the team.

4.64 We saw little evidence of the delivery of meaningful, evidence-based interventions. One-to-one interventions that we reviewed lacked structure and did not reflect patient need. Group work was not offered. Care plans lacked sufficient detail to inform interventions and were not person centred.

4.65 Support for patients requiring therapy was poor. A new psychologist had recently been employed but had yet to become embedded in the team. In addition, the team did not always identify patients who would benefit from therapies and opportunities were missed to improve outcomes for patients.

4.66 Joint working between mental health, other health care teams and the wider prison was not strong enough. Some departments were unaware

of the work of the mental health team or how it could support their work and described the team as isolated. Similarly, the mental health team did not have a good understanding of the needs of other departments and how to support them to improve patient outcomes.

4.67 Mental health staff did not attend all appropriate ACCT reviews (see paragraph 3.60) and thus were not always able to offer support to patients. Involvement by the mental health team was not effective at the ACCT reviews that we observed.

4.68 Patients receiving medications were regularly reviewed by a psychiatrist in line with national guidance.

4.69 Some patients waited for lengthy periods to be transferred to mental health facilities under the Mental Health Act. The provider took reasonable steps to try to reduce the delay, but the lack of available beds meant that some patients waited too long in an unsuitable environment.

Support and treatment for prisoners with addictions and those who misuse substances

4.70 NHFT delivered all clinical and psychosocial support to prisoners with drug and alcohol problems. Partnership working with the prison was reasonable. A coherent prison drug strategy had been developed but actions stemming from this had stalled.

4.71 At the time of the inspection, clinical treatment for 71 prisoners with drug and alcohol addictions focused appropriately on stabilisation and maintenance. Early days support was effective and prisoners experiencing withdrawal symptoms were well supported and appropriately observed. Recent staff departures had reduced the capacity and capabilities of the team. This placed a greater workload on the existing staff group who were working for extended hours to support newly arrived prisoners. Despite these pressures, treatment was flexible to meet individual need and case records indicated multi-disciplinary review and effective prisoner engagement. The considerable turnover of prisoners meant that care plans were basic, but in most cases preparation for release or transfer started early, which was positive.

4.72 The psychosocial ‘Supporting Change’ team, who were supporting 111 prisoners at the time of the inspection, were also experiencing substantial staff problems, albeit of a more transitory nature. Leaders had undertaken an analysis of need reflecting prisoners’ views, which was impressive. Changes had been made to the model of care to reflect this, with concentration on the most vulnerable patients and collective management of case loads. For example, prisoners who were unlikely to change their using habits on release were still seen, supported and given harm minimisation advice, but more intensive one-to-one and group work was targeted at those deemed most likely to benefit or considered to be at risk. The most intensive work was undertaken on D Wing, which was designated as the integrated drug

treatment services. Support included access to mutual aid, limited peer mentoring and a fair range of interventions which were all valued by prisoners we spoke to. There was support for prisoners on other wings, but access to group activities was not routinely available.

4.73 There was good support for prisoners preparing for release, with strong links with local services. A newly appointed 'Reconnect' practitioner was assigned to the prison with a brief to coordinate, oversee and enhance this work. Harm minimisation advice and access to Naloxone (a drug to alleviate the effects of opiate overdose) were provided, but uptake was low and the reasons for this were being explored.

Medicines optimisation and pharmacy services

4.74 Since the implementation of the new contract more than seven months previously, the effective management of medicines had proved challenging because of a shortage of staff and complicated contractual arrangements. This had only very recently started to improve.

4.75 CNWL were subcontracted to deliver pharmacy services and were responsible for dispensing named medication to patients on site, which they were able to do following an increase in staff levels.

4.76 CNWL were responsible for administering medication to patients on some wings and NHFT staff in other areas during the week and at weekends. Administration was undertaken by CNWL pharmacy technicians with the assistance of agency nurses and by NHFT nursing staff. We observed ID cards being routinely checked and the support of officers at the hatch was effective. The pharmacist was available on site if needed. Medicines were placed in reception for onward transfer for those going to court or being released.

4.77 There had for several months been a considerable backlog of medicine reconciliations (accurate listing of a patient's medication within 72 hours of arrival), but CNWL had arranged for external staff to complete these and they were now up to date.

4.78 Pharmacy services were running more smoothly, but we were uncertain about the management of and responsibility for out-of-hours medicines. The cabinet was not stocked with many items on the stock list and the list was not available in the cabinet. The stock control sheets were not completed correctly and we found expired medicines in the cabinet. This had contributed to delays in patients receiving medication and was poor practice. Once we identified this, the service agreed to rectify it.

4.79 Prescribing and administration was recorded on SystmOne. Medicines were supplied in original packaging for 28-day in-possession medicines and in plastic bags for seven-day in possession. Supervised medicines were administered three times a day and there was provision for night-time medicines.

4.80 A drugs and therapeutics committee had been meeting each month, but not for the last few months which created a gap in strategic oversight and a forum for discussion.

Dental services and oral health

4.81 Time for Teeth Limited was commissioned by NHSE to deliver dental services. The provision was well managed with a clear model of care. Governance structures were excellent.

4.82 A wide range of appropriate and high-quality treatments were available for patients. If patient needs could not be met in the prison, community treatment was sought in good time, although this happened rarely.

4.83 Waiting times were very short with a well-managed waiting list. Patients requiring emergency treatment were able to access emergency slots without delay.

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 recreational and social activities which support their well-being and promote effective rehabilitation.

5.1 Time out of cell was very poor and many prisoners received as little as an hour a day unlocked. The system for allocating prisoners to activities was inadequate, there was low attendance and frequent cancellations. About half the population was allocated to an activity but only about half of those attended.

5.2 In our roll checks, only 25% of prisoners were engaged in purposeful activity during the core working day and 45% were locked up.

5.3 There were frequent curtailments to the regime. During the last month, wings had been placed on restricted regime almost every day and units were not unlocked at all for part of the day. Leaders also frequently shut down activity areas such as the gym, education and library. On rare occasions, visits and health clinics were also cancelled. In our survey, only 21% of prisoners said that unlock times were usually adhered to compared with 50% in similar prisons.

5.4 The majority of work offered was part time and employed prisoners received up to 4.5 hours unlocked on the days they attended work.

5.5 In our survey, 67% of prisoners said they spent less than two hours out of their cell each day. Prisoners were frustrated that, within this limited time, they had to complete domestic tasks, take time outside, access showers and cleaning equipment and complete applications. In our survey, only 29% of prisoners said that they could go for outside exercise more than five days a week compared with 11% at our previous inspection, but 55% in similar prisons.

5.6 The indoor gym facilities were good, including a small sports court and a large cardiovascular and weights room. Most equipment was in reasonable condition and showers were being refurbished. The outdoor facilities were not in use because the outdoor artificial grass pitch was used as an exercise yard, and there were defects in the surface of the pitch.

5.7 The provision for time out of cell was limited; no qualifications were offered and there were not enough staff to run a full programme. The gym was only open from Monday to Friday, and for several months in

the spring of 2023 it had been closed completely because of the cross-deployment of staff.

5.8 Prisoners could attend up to two sessions of gym a week and data showed that 39% of the population were participating in gym activities. There was enough capacity to meet demand at the existing rate of engagement but not enough if demand increased.

5.9 The library was bright and welcoming, with a good range of material, including fiction, non-fiction, easy-reads and books in other languages. Each wing had weekly timetabled sessions, but prisoners struggled to gain access. Attendance was often hampered by closures to education and a lack of staff to escort prisoners.

5.10 There were a small range of initiatives to encourage reading, including reading challenges and reading groups, although uptake of these schemes was low. The Shannon Trust mentor scheme was in place (a charity which trains prisoners who can read to teach other prisoners), but mentors told us that they were not unlocked to facilitate sessions.

Education, skills and work activities

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

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

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

Overall effectiveness:	Inadequate
Quality of education:	Inadequate
Behaviour and attitudes:	Requires improvement
Personal development:	Inadequate

Leadership and management: Inadequate

5.12 There were enough part-time places in education, skills and work to accommodate the prison population. However, prison leaders did not use places in education, skills or work efficiently. In almost all prison activities, spaces were not maximised. Vacancies were not filled swiftly enough to ensure that prisoners had access to the education, skills and work they needed to help them with their next steps.

5.13 Leaders did not make sure that there were sufficient places in English and mathematics courses to meet the needs of prisoners. As a result, many prisoners who needed to develop their English and mathematics skills did not get the support they needed. This created a barrier to their rehabilitation journey.

5.14 Leaders had failed to design a vocational curriculum that was ambitious and met the needs of local and regional employers. The vocational curriculum was made up of a set of short courses offered in rotation that did not provide prisoners with enough substantial knowledge and skills in any of the vocational areas. Leaders had chosen subjects such as barbering, roofing and warehousing. There were no opportunities to gain accredited or valuable qualifications in these areas. Prisoners could not progress to higher-level courses, nor could they undertake appropriate pathways that supported their career choice.

5.15 Leaders did not make sure that prisoners in work developed high-level industry skills. Many areas such as cleaning did not have the equipment needed to develop the skills prisoners required to obtain work on release. Wing cleaners did not have access to floor buffers, polishers or vacuums. They often had to use the wrong equipment to clean, which compromised hygiene. This resulted in poor standards of cleaning that did not match the industry expectations. Prisoners were unenthusiastic and uninterested in the vocational warehousing programme which prison leaders had recently introduced to expand job training opportunities. Tutors did not use the initial assessment information to guide their teaching and they were unaware that one prisoner could not read. Other prisoners who were mandated to attend did not want to work in the warehousing industry. Because of this, prisoners lost interest in the programme and attendance dropped considerably.

5.16 Leaders did not ensure that workshops and industry areas were fit for working and learning purposes. Often the spaces provided were too small to accommodate the number of prisoners engaged in work. For example, in waste management, prison leaders were using the workshop as a storage area. This created a cluttered and unorganised environment where prisoners did not have the space they needed to sort waste effectively. This did not support them to develop and practise the necessary employability standards.

5.17 Leaders had not implemented an effective process to allocate prisoners to activities. Leaders met weekly with prison services to assign prisoners to education, skills or work. However, most of these meetings

focused on one wing at a time. Because of this, those prisoners who had a short stay at the prison could be leaving before they were allocated to activities. In a few cases, teachers circumvented the allocation process to ensure they had the correct number and capability of prisoners on their courses.

5.18 Prison leaders incentivised education programmes for prisoners by offering good local pay rates for attendance and bonuses for the completion of programmes. They made sure that local rates of pay for prisoners in education were superior to all other activities in the prison.

5.19 Leaders did not offer effective career education initial advice and guidance (CEIAG) for prisoners. The CEIAG process did not help prisoners make informed choices or advise the allocations board adequately. Staff shortages affected the completion of prisoners' personal learning plans and created a substantial backlog. Personal targets were of inconsistent quality. Too often, they did not focus on improving English and mathematics levels for those with low starting points. Because of the lack of staff, the allocation board did not include any CEIAG information. As a result, many prisoners did not have an appropriate individual learning plan to support their career objectives.

5.20 Leaders had successfully designed a modular curriculum for short-stay prisoners. They created small units of learning that gave prisoners the opportunity to achieve a qualification successfully. The teachers were suitably qualified and experienced and most prisoners who stayed on their courses passed.

5.21 Most teachers in education planned lessons effectively. They grouped information to help prisoners memorise new concepts better. For example, in mathematics, prisoners engaged in estimating the height of filing cabinets, the weight of classroom items such as calculators, books and the volume of water in a jug. They then completed measuring and weighing activities to check their estimations. Teachers used various activities, like word searches and reading aloud, to assess learning and correct misunderstandings.

5.22 Teachers used peer mentors effectively in the classrooms. They acted as buddies to help prisoners with specific learning difficulties or lower levels of understanding in lessons. As a result, prisoners gained confidence and progressed at a similar rate to their peers.

5.23 Leaders had been slow to put in place a suitable reading strategy. Two teachers had received training in phonics and were using their skills successfully to support two prisoners in education who could not read. Leaders had introduced an initial assessment for prisoners but it was only completed by a small minority. Many prisoners did not complete their English or mathematics assessments or attend education inductions. Consequently, it was not clear how many prisoners needed support with their reading skills.

5.24 Leaders did not do enough to promote reading for pleasure in the wider prison nor did they offer enough opportunities for prisoners who were

not in education to improve their reading abilities. Storybook Dads was available in the library (see paragraph 6.6) and there was a book area on the wings, but many prisoners chose not to attend or use these facilities.

5.25 Tutors in work and industries did not help prisoners with reading, English or mathematics. Spelling and grammar mistakes on prisoners' work were often not corrected. As a result, prisoners continued to make the same mistakes and did not cultivate their reading skills.

5.26 Leaders failed to ensure that tutors monitored the progress in workshops effectively. Tutors did not routinely record skills such as timekeeping, attitudes, work ethic or the performance of prisoners. In bicycle recycling, prisoners could work on bicycles for six to eight months without keeping track of what they had learned. As a result, prisoners were not aware of the technical knowledge or skills they had developed, nor could they provide this information to future employers.

5.27 Leaders had failed to ensure that prisoners' attendance at education was high. Only half the prisoners turned up to their sessions and leaders cancelled classes. However, attendance at work or industries was much better, with most prisoners attending routinely.

5.28 Prisoners' behaviour in education, work and skills had considerably improved since the previous inspection. Prisoners were respectful to their peers and staff and most prisoners demonstrated positive attitudes to their learning. For example, they made valuable and enthusiastic contributions to class-based discussions. In music technology lessons, prisoners focused on the development of new skills. Most learning environments in education were positive and calm. Consequently, prisoners collaborated well with each other and their tutors.

5.29 Prison leaders had not created a curriculum that supported prisoners' personal growth. Prisoners could undertake activities like music, art, games and a few personal development lessons in education. However, the uptake of these courses was too low. Many prisoners were not aware of them or how to attend. As a result, prisoners did not know about the available resources that could help them become responsible citizens after they were released.

5.30 Leaders did not ensure that vulnerable prisoners could take the same extracurricular courses as their peers. Leaders had modified educational courses to increase accessibility through an outreach programme. However, they did not make sure that vulnerable prisoners could join all available enrichment programmes. Prison leaders had made it harder for vulnerable prisoners to develop their wider skills and interests.

5.31 Leaders had failed to respond quickly enough to the weaknesses found during the previous inspection. They had not done enough to stem the decline of poor-quality education, skills and work. Only two of the seven concerns raised in the previous inspection had been suitably met.

5.32 Prison leaders had regular meetings with key staff to review the quality of education, skills and work. Each service area provided a report or overview of their provision. Consequently, leaders were broadly aware of the concerns. However, they failed to address them appropriately. Leaders and managers did not use the information available to them to secure a good understanding of curriculum planning. For example, they did not know how elements of the education and skills provision were funded.

Section 6 Preparation for release

Preparation for release is understood as a core function of the prison. 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 understands the importance of family ties to resettlement and reducing the risk of reoffending. The prison promotes and supports prisoners' contact with their families and friends. Programmes aimed at developing parenting and relationship skills are facilitated by the prison. Prisoners not receiving visits are supported in other ways to establish or maintain family support.

6.1 In our survey, prisoners were more negative about their contact with families and friends than at similar prisons. The usual range of options for maintaining family contact were offered, including social visits, secure video calls (see Glossary), phone calls, letters and emails via the email-a-prisoner service. Staffing shortfalls had recently had a detrimental impact on several of these options.

6.2 Family support services were contracted to Invisible Walls which was a change of provider since the 2022 inspection. Staff and volunteers offered a welcome and advice at the visitors' centre adjacent to the prison. Visitors were appreciative of the help available in the centre.

6.3 Four sessions were offered each week, with up to 20 social visits possible at each. This was limited capacity for a prison with a large remand population who were entitled to three visits a week. Most sessions were largely or fully booked and leaders were planning to introduce additional sessions early in 2024.

6.4 The social visits hall was welcoming with a well-equipped play area for children overseen by Invisible Walls who also ran the tea bar and arranged family days throughout the year. A 'book hut' (from which children could select a book to start reading with the prisoner they were visiting and take home to continue reading) was nearly ready to open. A well-being group run by Invisible Walls for prisoners who did not have social visits was due to start shortly after the inspection.

Social visits hall

6.5 Prisoners and some visitors described difficulties with the social visits booking arrangements and these were not consistent when the regular booking clerk was absent. Leaders were looking at how technology could be used to improve the arrangements.

6.6 The chaplaincy had recently started a parenting course and, after a gap in provision, the library now offered prisoners the opportunity to use Storybook Dads to record themselves reading a story for a child relative.

6.7 Ten visits sessions had been cancelled over the previous year, which was poor. Similarly, secure video call sessions had been cancelled, largely because of staff constraints. The use of secure video to maintain community contact was low and most sessions were not offered at times suitable for working families and their children.

6.8 Prisoners' mail was not consistently delivered promptly to residential wings. In-cell telephones remained a benefit but cell sharing and the time prisoners spent locked up together precluded privacy during calls.

Reducing reoffending

Expected outcomes: Prisoners are helped to change behaviours that contribute to offending. Staff help prisoners to demonstrate their progress.

6.9 Since the previous inspection, there had been substantial changes in leadership in the area of preparation for release. Functional heads, some of whom had been appointed recently, were aware of what needed to improve and could describe their plans.

6.10 The strategy for reducing reoffending was being reviewed at the time of the inspection. Work to reduce reoffending was reasonably well coordinated at strategic and individual prisoner levels. Co-ordinated working was aided by regular reducing reoffending meetings and the co-location of the offender management unit (OMU), pre-release team and other staff who supported resettlement, including the prison employment lead, bank account and identity document worker, housing workers and the bail liaison officer.

6.11 The primary function of the prison was to serve local courts and the majority of prisoners were on remand (49%) or waiting to be sentenced (14%). They could access reasonable support with immediate needs when they arrived. Basic custody screenings were not consistently completed by prison staff but new arrivals were interviewed promptly by a member of the pre-release team to prepare an initial resettlement plan. These interactions addressed immediate matters like housing, benefits and financial commitments. A bail liaison officer worked with prisoners on remand. An updated remand strategy had recently been developed with actions to improve help for remanded prisoners, but it was too soon to assess its effectiveness.

6.12 A minority of the population needed sentence planning and offender management. Each of these prisoners was allocated to a prison offender manager (POM). The OMU was almost fully staffed but had experienced several changes of personnel since the inspection in 2022. Leaders were managing sick leave in the case administration team and the frequent cross-deployment of a part-time POM. There had been no senior probation officer (head of offender management delivery) in the OMU for several months at the start of 2023, but this had been remedied in May 2023. Supervision sessions and quality assurance of POM work were now in place.

6.13 Most prisoners transferred to a training prison shortly after being sentenced and there was not often a requirement for a POM to complete an assessment of risk and need (an OASys assessment). In most of the cases that we reviewed, assessments had been completed by a community offender manager (COM) and all had an up-to-date OASys (less than a year old), which was very good. Not all prisoners in our review group had risk management plans or sentence plans and not enough was done to focus on prisoners who spent only a short time in Bedford and did not have a sentence plan.

6.14 Most sentence plans were of at least a reasonably good standard and included multiple targets focused on engagement with drug and/or alcohol services, education, training and employment and compliance with the regime. Overall, progress against sentence plan targets was inadequate in most of our sample. There was little evidence of POMs delivering one-to-one work which would have been relevant for some of the prisoners who stayed for a longer period. Examples of better work included a prisoner who had spent long periods in segregation who had received excellent one-to-one psychology support.

6.15 POMs each had a caseload of about 25 sentenced prisoners and had reasonably good knowledge of their cases, although most of the prisoners we interviewed were unable to name their POM. In our survey, 24% of prisoners said that staff were helping them to progress.

6.16 Prisoners, whether remanded or convicted, had access to wing surgeries and a daily duty POM to help resolve concerns. This was helpful given the absence of regular key work (see Glossary) to support offender management and prisoners on remand (see paragraph 4.3). However, rather than focused work with their allocated case loads, POMs spent time addressing issues that should have been dealt with by a key worker. The level of recorded contact between POMs and their allocated prisoners was insufficient in many cases. There were some notable exceptions, for example the case notes of a recalled prisoner with an indeterminate sentence for public protection demonstrated much work by the POM before and after the Parole Board hearing. This was supported by a good contribution by the psychology team.

6.17 A small number of prisoners were released early on home detention curfew (HDC), about a third of whom were released after their eligibility date. Most delays were caused by the lack of suitable accommodation or the time taken for community checks for prisoners becoming eligible for HDC shortly after being sentenced. There was evidence in electronic records of POMs actively pursuing the provision of accommodation for those with no suitable address.

6.18 The end of custody supervised licence arrangements had been used to release 16 suitable prisoners and a few newly sentenced prisoners had been assessed as suitable for open conditions as part of the temporary re-categorisation scheme.

6.19 Prisoners were given a security categorisation soon after sentencing and most were assessed as suitable for category C conditions. They were transferred promptly to serve their sentence which for some entailed moving when they were already in their resettlement or HDC phase. Those with more specific needs, for example prisoners convicted of sexual offences or category B prisoners moving to the long-term estate, could experience longer waits to transfer.

6.20 The small number of indeterminate sentenced prisoners were mostly on recall or had returned from hospital. There was no specific support

for them, although consultation with them started at the time of the inspection.

Public protection

Expected outcomes: Prisoners' risk of serious harm to others is managed effectively. Prisoners are helped to reduce high risk of harm behaviours.

6.21 The OASys assessment for most prisoners included a risk management plan and most of those that we reviewed were at least reasonably good. Two had been written by a probation POM and in each case the risk management plan was good.

6.22 There was not enough evidence of prompt escalation to community leaders to make sure that MAPPA (multi-agency public protection arrangements) levels were confirmed before release. POM attendance at MAPPA panels was good and MAPPA information-sharing forms were completed to a reasonably good standard. Those written by probation POMs were more detailed and analytical. OMU leaders had developed a good working relationship with the local MAPPA Board coordinator.

6.23 All new arrivals were reviewed and appropriate contact restrictions applied which POMs explained to prisoners. At the time of the inspection, 41 prisoners were subject to child contact restrictions. These were not reviewed annually, an omission that OMU leaders had started to address.

6.24 Ten prisoners were subject to phone and mail monitoring at the time of the inspection. The very lengthy delays in listening to phone calls reported at the previous inspection no longer happened but a shortage of staff had delayed listening to some calls for up to two weeks, which was too long. The small number of staff who undertook frequent monitoring maintained good logs that enabled informed decisions to be made about the need for continuing monitoring. Mail monitoring was less robust which leaders planned to address with training and clear performance expectations.

6.25 The monthly interdepartmental risk management meeting gave reasonable oversight of higher-risk prisoners but attendance by areas other than the OMU was inconsistent which hampered its effectiveness. The meeting that we attended was purposeful with resolution of some issues and clear actions to take forward.

Interventions and support

Expected outcomes: Prisoners are able to access support and interventions designed to reduce reoffending and promote effective resettlement.

6.26 No accredited offending behaviour courses were offered, which was in keeping with the prison's function. Some interventions were offered to meet specific needs, for example substance misuse. The chaplaincy supported prisoners who had been bereaved and ran victim awareness (Sycamore Tree) group work. They had recently introduced a parenting course.

6.27 Several of the young adult population lived in a discrete unit with bespoke support from POMs. They could participate in the locally designed STRIDE programme (to help young adults with behavioural problems), although this depended on staffing levels (see paragraph 4.26). A community social enterprise group, the Salam project, had delivered workshops over the previous year for young adults on a range of topics.

6.28 The focus on employment for release had been strengthened with the introduction of a prison employment lead and an employment hub under the aegis of New Futures Network (which brokers partnerships between prisons and employers). Contacts were being made with employers, job fairs had started, coaching sessions had taken place and some prisoners had secured interviews and, a few, employment. An employment advisory board met regularly to support this work. The employment hub was a suitable environment for prisoners to have interviews with prospective employers either in person or virtually and was also used for private interviews with a Jobcentre Plus work coach for benefits and work advice.

Employment hub

6.29 Since January 2023, sentenced prisoners nearing release had received help to open bank accounts and obtain identification. By the end of August 2023, more than 100 prisoners had obtained their birth certificate and 31 bank accounts had been opened.

6.30 Too many sentenced prisoners were recorded as having been released homeless (30%) or to unsustainable accommodation (42%) over the previous year. There were no data about accommodation for the more than 300 prisoners who had been released from court. The appointment of a strategic housing specialist and the recent formation of a housing advisory board aimed to improve these outcomes.

Returning to the community

Expected outcomes: Prisoners' specific reintegration needs are met through good multi-agency working to maximise the likelihood of successful resettlement on release.

6.31 Low- and medium-risk prisoners nearing release were supported by the pre-release team who contacted them 12 weeks before their release (or less if they had a short time to serve) to review their resettlement plans and make necessary referrals. The release of high-risk prisoners was planned by their COM and in some cases prison staff had to make persistent contact with COMs to finalise release arrangements. In cases that we sampled, bank accounts had been opened, birth certificates obtained, Job Centre appointments arranged for the day of release and housing referrals and assessments undertaken. Interviews

and actions taken were recorded on electronic case notes and/or OASys to update other staff working with prisoners.

6.32 Progress with release plans was reviewed four weeks before release with agencies involved in the process. Prisoners were not involved in these meetings which leaders intended to change. This was a missed opportunity to provide reassurance and information to prisoners given the low number in our survey who said they were getting the help they needed as they approached release.

6.33 The arrangements for the day of release were adequate. There were clothes in reception for prisoners who needed them and plain bags to carry property in. Searching was proportionate and mobile phones could be charged for a short period before leaving reception. The absence of the departure lounge, which was identified as notable positive practice at our last inspection, was a deficit that leaders were addressing.

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.

Safety

Prisoners, particularly the most vulnerable, are held safely.

At the last inspection in 2022, we found that outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

All violent incidents should be investigated and findings should inform the strategy to reduce violence. CSIPs should be used to address violence and antisocial behaviour, and to support victims.
Achieved

Body-worn cameras should be routinely switched on during incidents, and both footage and written records should demonstrate the use of de-escalation before and during use of force.
Achieved

Prisoners on the segregation unit should be held in decent conditions.
Achieved

Recommendations

Staff on the induction wing should demonstrate that they are supporting prisoners through their first days in custody through properly completed Early Days in Custody documents.
Not achieved

Prisoners' PIN phone numbers should be added to their accounts within 24 hours of arrival, to enable them to contact their families.
Not achieved

Formal support should be provided for victims of antisocial behaviour or violence.
Achieved

Leaders should investigate why so many prisoners refused to attend their adjudications.
Achieved

Every use of batons and PAVA spray should be fully investigated and reviewed by a senior prison manager.
Achieved

Special accommodation should be used in the most exceptional circumstances and should not be used as a punishment. Thorough records should be kept of its use.
Achieved

All unplanned incidents should be recorded and footage retained.
Achieved

Reintegration plans should be developed for prisoners held on the segregation unit with individual action plans and targets to help them move back into the general population.
Not achieved

Intelligence reports should be analysed and processed quickly.
Achieved

Leaders should make sure that there are consistent and detailed records of the number of prisoners who have been subject to constant watch and anti-ligature clothing, and for how long.
Not achieved

Wing staff should routinely engage in meaningful conversations with prisoners on ACCTs, and these should be recorded on ACCT documents and electronic records.
Achieved

Data analysis should be developed to support the identification and delivery of strategic priorities for the reduction of self-harm.
Not achieved

Respect

Prisoners are treated with respect for their human dignity.

At the last inspection in 2022 outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

Managers should investigate the causes of poor morale and the lack of focus on prisoner care among some staff and should ensure that staff development initiatives address these concerns.
Partially achieved

Managers should implement a programme of renovation to improve the quality and decency of cells designed for single occupancy and these cells should be used to accommodate one prisoner only.
Not achieved

Managers should investigate the reasons for the failure to respond to emergency cell bells and implement measures to make sure that they are answered within the target time.
Not achieved

Leaders should ensure that prisoners with protected characteristics are systematically identified and given consistent and good quality support.
Not achieved

Recommendations

Leaders should ensure that prisoners with protected characteristics are systematically identified and given consistent and good quality support.
Not achieved

All staff should complete reports on Datix, the on-line clinical incident system, so that they can be fully investigated and trends can be monitored and addressed.
Partially achieved

Custody escort arrangements should be strengthened to meet the health care needs of all prisoners.
Achieved

Patients requiring treatment in hospital under the Mental Health Act should be transferred within the current guidelines.
Not achieved

Supervision by prison officers of medicine administration should enable compliance, promote confidentiality and minimise the risk of diversion.
Not achieved

Purposeful activity

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

At the last inspection in 2022 outcomes for prisoners were not sufficiently good against this healthy prison test.

Key recommendations

Leaders should ensure that during the working day all prisoners are able to spend a substantial period out of their cells and in purposeful activity.
Not achieved

Leaders should make sure that more prisoners can access the education they need promptly and that waiting lists are reduced significantly.
Not achieved

Recommendations

Exercise periods should be provided consistently and for 60 minutes' duration.
Not achieved

The gym should be open consistently and should provide a full range of activities, including the delivery of accredited courses.
Not achieved

Leaders should ensure that prisoners have consistently high attendance and punctuality at education, skills and work activities.
Not achieved

Leaders should ensure that vulnerable prisoners have access to the full education, skills and work programme equivalent to their peers.
Not achieved

Leaders should ensure that prisoners are able to achieve relevant vocational qualifications that meet their interests and aspirations.
Not achieved

Leaders should ensure that, in line with their own expectations, the recording and recognising of employability skills should be maintained in all workshops, training and work areas.
Not achieved

Leaders should ensure that prisoners have sufficient opportunities to take on roles of responsibility so that they can contribute effectively to the prison community.
Achieved

Leaders should ensure that all staff in education, skills and work consistently challenge instances of poor behaviour and use of derogatory language by prisoners.
Achieved

Leaders should ensure that all vocational training and work environments are fit for purpose and fully equipped and meet industry standards.
Not achieved

Preparation for release

Preparation for release is understood as a core function of the prison. 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 2022 outcomes for prisoners were reasonably good against this healthy prison test.

Key recommendations

Monitoring of telephone calls for public protection purposes should be carried out regularly, with translation where the call is not in English.
Achieved

Managers should design and implement a comprehensive system of practical support to make sure that all prisoners go to the most suitable accommodation possible on release, with clear measures of success or failure.
Not achieved

Recommendations

Incoming and outgoing mail should pass between the prison gate and the prisoner within 24 hours on weekdays.
Not achieved

A comprehensive service should give proper support and advice to all prisoners facing difficulties with finance, benefits and debt.
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.

Preparation for release
Preparation for release is understood as a core function of the prison. 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.

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

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

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

concerns. Procedures to safeguard outcomes are in place.

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

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

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

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

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

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

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

This report

This report outlines the priority and key concerns from the inspection and our judgements against the four healthy prison tests. There then follow four sections each containing a detailed account of our findings against our *Expectations. Criteria for assessing the treatment of and conditions for men in prisons* (Version 5, 2017) (available on our website at

https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/prison-expectations/). Section 7 lists the recommendations from the previous full inspection (and scrutiny visit where relevant), and our assessment of whether they have been achieved.

Findings from the survey of prisoners and a detailed description of the survey methodology can be found on our website (see Further resources). Please note that we only refer to comparisons with other comparable establishments or previous inspections when these are statistically significant. The significance level is set at 0.01, which means that there is only a 1% chance that the difference in results is due to chance.

Inspection team

This inspection was carried out by:

Charlie Taylor	Chief inspector
Angus Jones	Team leader
Esra Sari	Inspector
Angela Johnson	Inspector
David Foot	Inspector
Donna Ward	Inspector
Martyn Griffiths	Inspector
Rick Wright	Inspector
Helen Ranns	Researcher
Helen Downham	Researcher
Sam Moses	Researcher
Isabella Henry	Researcher
Maureen Jamieson	Lead health and social care inspector
Stephen Eley	Health and social care inspector
Jennifer Oliphant	Pharmacist
Jacob Foster	Care Quality Commission inspector
Bev Ramsell	Ofsted inspector
Vicki Locke	Ofsted inspector
Darryl Jones	Ofsted inspector
Rob Mottram	Ofsted inspector

Appendix II Glossary

We try to make our reports as clear as possible, and this short glossary should help to explain some of the specialist terms you may find. If you need an explanation of any other terms, please see the longer glossary, available on our website at: http://www.justiceinspectorates.gov.uk/hmiprisons/about-our-inspections/

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

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

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

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

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

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

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

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

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.

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

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

Appendix III Care Quality Commission Requirement Notice

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

The inspection of health services at HMP Bedford 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
Northamptonshire Healthcare NHS Foundation trust.

Location
HMP Bedford

Location ID
RP1X5

Regulated activities
Treatment of disease, disorder or injury, Surgical procedures, 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 10(1) Dignity and respect
(1) Service users must be treated with dignity and respect.

(2) Without limiting paragraph (1), the things which a registered person is required to do to comply with paragraph (1) include in particular:

(a) Ensuring the privacy of the service user;

(b) Supporting the autonomy, independence and involvement in the community of the service user;

(c) Having due regard to any relevant protected characteristics (as defined in section 149(7) of the Equality Act 2010) of the service user.

How the regulation was not being met
During the inspection we identified one service user who received inappropriate care. Use of force footage obtained by HMIP (His Majesty's Inspectorate of Prisons) showed a service user being restrained by three prison officers in their cell on the inpatient ward. A nurse tells the service user they need an injection (later identified as Pabrinex). On multiple occasions, the service user clearly does not give consent however the nurse administers the medication.

During the incident, staff failed to treat the service user with dignity and respect or provide care in a caring and compassionate way when administering medication. The service user was restrained with the sole purpose of administering medication with no clear rational for doing so.

Staff failed to respect the service user's personal choice and independence. Footage of the incident clearly confirms the service user did not wish for the nurse to administer medication however this was ignored.

Regulation 11(1) Need for consent
(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
As outlined in Regulation 10, during the inspection of HMP Bedford week commencing 6 November 2023 we identified one service user who received care without consenting.

Footage of the incident clearly demonstrates the service user was administered medicines without their consent. The service user asks staff several times not to administer the medication. However, this request was ignored.

The service user was not given all the required information to make an informed decision about the proposed care. The footage of the incident shows the service user being told "You need an injection."

Consent was not sought from the service user and no discussion about consent took place. Footage of the incident shows consent was not implied. Records relating to the incident state the service user consented to treatment however the footage we saw contradicts this.

The service user clearly did not consent to treatment at any point during the administration of medicines however, this was not recognised or respected by nursing staff who continued to administer the medication.

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

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