Report on an independent review of progress at

HMP Lowdham Grange

by HM Chief Inspector of Prisons

8–10 January 2024

Contents

Section 1 Chief Inspector's summary

1.1 HMP Lowdham Grange, near Nottingham, is a category B training prison capable of holding up to 900 adult men, many convicted of very serious offences. It first opened under private contract in 1998 and was operated by Serco for 25 years. Following a competition and market test, the contract was transferred to Sodexo in February 2023, making Lowdham Grange the first contracted prison to transfer between two private sector providers.

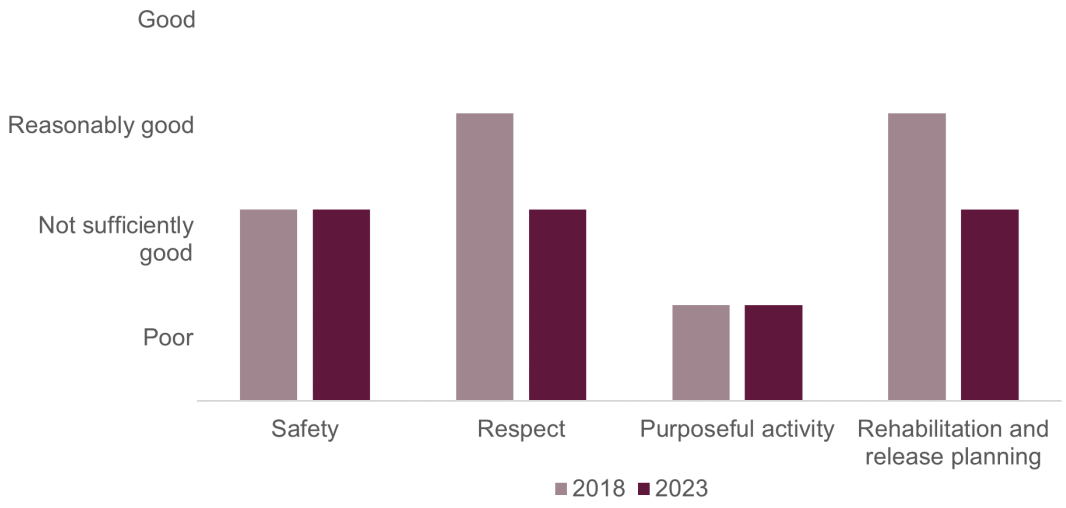
1.2 In the months following our full inspection, the Ministry of Justice and senior HM Prison and Probation Service (HMPPS) leaders (see Glossary) considered that conditions at the prison had deteriorated so significantly that, on 18 December 2023, it was announced that HMPPS would activate the 'step-in' procedure (see paragraph 1.7) to stabilise the prison, in accordance with the Criminal Justice Act 1991, and as part of its contract management arrangements with Sodexo.

1.3 This review visit followed up on the concerns we raised at our last inspection of Lowdham Grange in May 2023, and on 6 October both Sodexo and HMPPS were given notice of our proposed visit, in line with the independent review of progress (IRP) protocol.

What we found at our last inspection

1.4 At our previous inspections of HMP Lowdham Grange, in 2018 and 2023, we made the following judgements about outcomes for prisoners.

Figure 1: HMP Lowdham Grange healthy prison outcomes in 2018 and 2023
Note: rehabilitation and release planning became 'preparation for release' in October 2023.



1.5 At the last full inspection, in May 2023, we found an atmosphere of uncertainty and anxiety, among both staff and prisoners, following the transfer of contract from Serco to Sodexo. A new director had been

appointed shortly before the inspection, but leaders were still grappling with many issues, including the loss of some key specialist staff, a lack of understanding of new routines and a widespread perception among prisoners and staff that communication from leaders was poor. The prison was not safe, with high levels of violence and easy access to illicit drugs. Oversight of use of force and segregation were not good enough. We were also concerned that there had been three self-inflicted deaths in March, shortly after the transition, prompting speculation among staff and prisoners that uncertainty and change had been causal factors.

1.6 Prisoners expressed frustration that basic requests were not being dealt with, and outcomes in health care were undermined by staff shortages and inadequate oversight of services. The prison was also failing to fulfil its rehabilitative function, with an inconsistent regime and poor access to work and education. Many prisoners posed a high risk of harm, yet offender management, public protection and resettlement services all needed to improve.

1.7 After the last inspection, I said that Lowdham Grange was struggling, and to some extent this was predictable in the context of transition from one provider to another. Leaders were sighted on the concerns that we identified, but they needed support and encouragement to make sure that they were addressed expeditiously.

What we found during this review visit

1.8 In the period following our last full inspection, HMPPS senior leaders decided that, despite the efforts of HMPPS Custodial Contracts Directorate and Sodexo to improve standards, conditions had deteriorated further. Therefore, on 18 December 2023, the Ministry of Justice announced that HMPPS would take over the operational management of the prison for an interim period, to improve safety and security at the prison. The process known as ‘step-in’ allows the Secretary of State to intervene when there are serious concerns over the operation of a privately run prison and the provider’s capacity to fulfil the obligations set out in the contract. The step-in process enabled immediate actions to be taken, including the deployment of an experienced HMPPS governor to take on operational command of the prison and additional HMPPS staff, including prison officers on detached duty, to bolster staffing levels. The process also required Sodexo to develop an improvement plan to inform decision making on the future management of the prison.

1.9 At this independent review of progress, we considered whether leaders had made progress against five of our priority concerns, two key concerns and three themes identified by Ofsted. Our review took into consideration evidence of progress in the months before and weeks after step-in. It was clear that outcomes for prisoners had declined further, and it was extremely concerning that we identified no meaningful progress in five of our concerns, including two of the most critical relating to safety. We also found insufficient progress in both of our concerns relating to offending behaviour and public protection.

Ofsted found that there had been reasonable progress in all of the three themes they reviewed.

1.10 Prior to the step-in process there had been a change of director at the prison in early October 2023. The new director quickly established where there were significant shortfalls and created a strategy that was intended to address the basics of safety, staffing, the regime and improving partnerships with key stakeholders, such as the health provider.

1.11 However, despite the director recruiting experienced managers from other Sodexo prisons to support this strategy, the challenges were great and the potential for improvement was hindered by serious staffing shortfalls. Between the start of the contract in February 2023 and up to December 2023, 127 staff had resigned, with frontline prison custody officers (PCOs) accounting for 57% of this attrition. Data provided by Sodexo suggested that there was a shortfall of 51 PCOs in November.

1.12 It was therefore not surprising, given the staffing situation, that even the very basic needs of prisoners were often not met. The regime was often curtailed, and prisoners and staff alike told us that it was not uncommon for prisoners to be locked up for very long periods, which understandably caused frustration and risked both stability and safety.

1.13 Since the step-in process, both the HMPPS governor and the Sodexo director had identified a series of immediate priorities. Prison officers, with varying degrees of experience, were deployed by HMPPS to help support the delivery of a more consistent regime; HMPPS had arranged for a reduction of the population by around 60 prisoners, to improve stability and facilitate a refurbishment programme; and the governor had arranged for assistance from regional HMPPS teams to conduct searches, resulting in the removal of 650 litres of illicitly brewed alcohol.

1.14 However, in the months following the full inspection, violence had increased and still not enough was being done to investigate incidents or challenge perpetrators. Security intelligence systems had become very weak and disciplinary processes had all but collapsed. There had been a further two self-inflicted deaths since the full inspection, one of which involved a segregated prisoner, and was currently the subject of external investigations. While some prisoners reported positive care, there were weaknesses in assessment, care in custody and teamwork (ACCT) case management processes for prisoners at risk of suicide or self-harm, and levels of self-harm had increased considerably.

1.15 There had been a very recent drive to improve cleanliness and ensure that prisoners received basic entitlements, but several areas of the prison remained grubby and access to basic cleaning materials varied greatly across the prison. A recruitment drive had led to some improvement to the health provision, but relationships between the health provider and Sodexo prison leaders were strained. The instability of the prison and concerns from health care staff about their

personal safety had resulted in only minimal and critical health services being delivered for extended periods.

1.16 While Ofsted recognised that there had been an improvement in the education, skills and work provision, the inconsistency of daily routines meant that too few prisoners had been able to attend education, particularly English and mathematics classes, and there was an over-reliance on employing wing cleaners to make up activity spaces. There had been some early signs of improvement in the recruitment of psychologists and other staff to support the delivery of offending behaviour programmes, but some aspects of public protection procedures needed more attention.

1.17 While the outcomes of this review were not entirely surprising given the upheaval in recent months, this was obviously a very disappointing visit. Initiating the step-in process is rare, and there remains much uncertainty. For example, the Sodexo prison director retains responsibility for the delivery of the contract, but the HMPPS governor has operational control. Their relationship is encouraging and professional, but there is the potential for dispute should future operational delivery not align with contractual requirements. There will also need to be consideration of how to mitigate the failures seen at Lowdham Grange when future contracts are awarded.

1.18 The leaders we met seemed to have the energy and capability to drive improvement going forward. However, to do so they will need assurance from HMPPS that the population will not increase, the prison will be appropriately resourced, and experienced senior leaders will continue to support Sodexo staff until the long-term future of the prison is decided.

Charlie Taylor
HM Chief Inspector of Prisons
January 2024

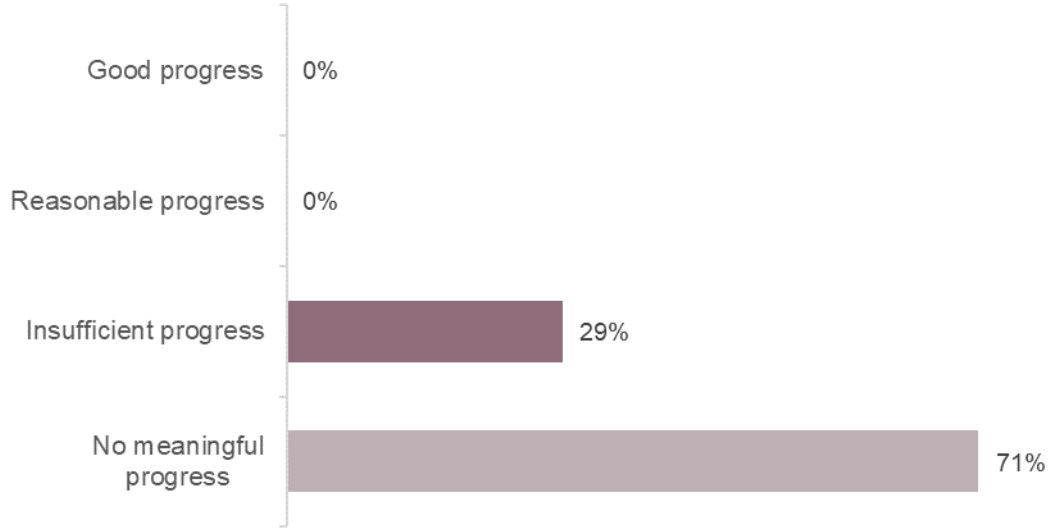
Section 2 Key findings

2.1 At this IRP visit, we followed up seven concerns from our most recent inspection in May 2023 and Ofsted followed up three themes based on their latest inspection or progress monitoring visit to the prison, whichever was most recent.

2.2 HMI Prisons judged that there was insufficient progress in two concerns and no meaningful progress in five concerns.

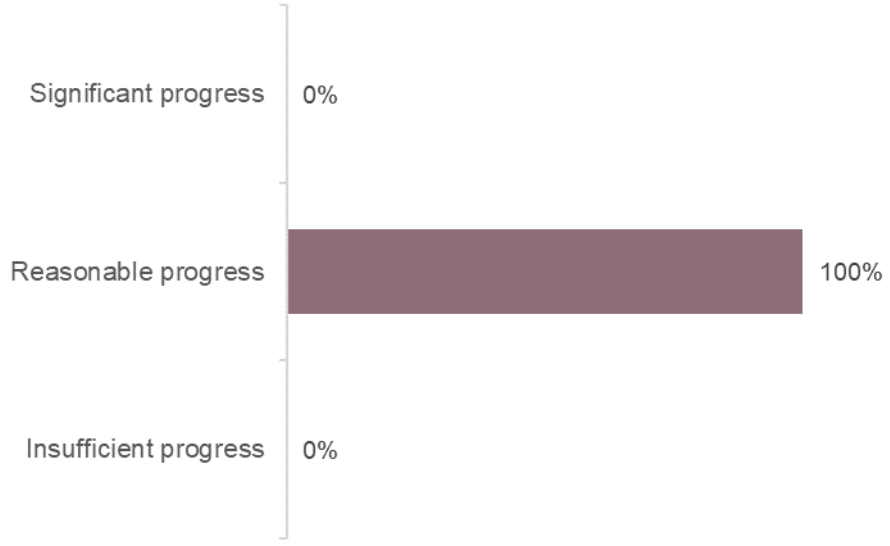
Figure 2: Progress on HMI Prisons concerns from May 2023 inspection (n=7)

This bar chart excludes any concerns that were followed up as part of a theme within Ofsted's concurrent prison monitoring visit.



2.3 Ofsted judged that there was reasonable progress in all three themes.

Figure 3: Progress on Ofsted themes from May 2023 inspection.



Notable positive practice

2.4 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.

2.5 Inspectors found no examples of notable positive practice during this independent review of progress.

Section 3 Progress against our concerns and Ofsted themes

The following provides a brief description of our findings in relation to each concern followed up from the full inspection in 2023.

Managing behaviour

Concern: The prison was not safe enough. Outcomes were being undermined by violence, the ready availability of illegal drugs and an inexperienced staff group who lacked the confidence to provide effective supervision and management.

3.1 Recorded rates of violence were 55% higher in last six months than in the six months before the full inspection. The proportion of assaults that were serious remained similar, at around one-fifth, but the proportion of assaults against staff had increased from 35% to 44%.

3.2 During the visit, we identified some instances of poor recording, which meant that we could not be confident that all incidents were logged appropriately. The prison's assurance team also gave us an example of where an assault identified in adjudication paperwork had not been correctly recorded on incident reporting systems.

3.3 The safer custody team had not been sufficiently resourced and members were often redeployed to support other areas of the prison. This meant that key aspects of prisoner safety, such as investigating violent incidents, were not being done.

3.4 Challenge, support and intervention plans (see Glossary) were rarely used, or were of poor quality, neither challenging perpetrators of violence nor supporting them to change their behaviour.

3.5 There were currently around 20 prisoners self-isolating because they feared for their safety on the wings. They had a very poor regime and there was insufficient oversight of their welfare; for example, some told us that they continued to receive verbal abuse from other prisoners, and some had derogatory graffiti daubed on their cell doors that had not been removed.

Graffiti on cell door of self-isolating prisoner

3.6 During our visit, we observed frequent low-level poor behaviour. For example, prisoners were often vaping in communal areas or were dressed inappropriately, and in some instances openly defied staff authority. Evidence suggested that prison custody officers (PCOs) did not always have the confidence to challenge prisoners, because of the increase in violence directed towards them when they did. In another case, a prisoner was returned to standard privileges five days after the assault of a female PCO, without any consideration given to disciplinary proceedings or appropriate targets being set to improve his behaviour.

3.7 Adjudications provided little deterrent to poor behaviour, and disciplinary procedures needed urgent improvement. Despite numerous requests during our visit, data in relation to the number of outstanding charges were not provided; we were given conflicting reasons for this, although the most likely explanation was simply that leaders did not know. We were told that there were over 2,000 outstanding charges and possibly as many as 2,400. An experienced middle manager from HMPPS told us that, in the week before our visit, around 200 charges had been dispensed with, to reduce the backlog.

3.8 Even more recent breaches of discipline had not been dealt with correctly. For example, following a targeted search over Christmas to remove illicitly brewed alcohol ('hooch'), a large number of prisoners (over 30) had been placed on report for allegations of possession of unauthorised items (see below). Leaders told us that not one adjudication had been dealt with in the specified timescales, so none had been proceeded with, despite the large quantities of hooch being recovered.

3.9 Illicit drug use had increased; HMPPS data showed that around 40% of prisoners had tested positive during random drug tests over the past six months, compared with 19% in the same period before the last full inspection.

3.10 Very few security reports were submitted, which presented a risk to the stability of the prison. For example, in the November 2023 security assessment, there were only three recorded intelligence reports relating to drug use, despite the widespread substance misuse across the establishment and drugs being considered a serious risk by the prison for over 12 months.

3.11 Since the HMPPS step-in, additional resource had increased the number of searches taking place, with a commensurate increase in the number of illicit items found. A targeted search over the Christmas period had led to over 600 litres of hooch being recovered (see above).

3.12 More positively, there was very early evidence that actions taken since step-in, had begun to improve safety and reduce protesting behaviour (see information supplied by the prison in the table below).

Incident type	1-17 December 2023	18-31 December 2023
Cell fires	13	0
Damage to prison property	20	7
Self-harm incidents	68	29
Total assaults (serious)	25 (6)	17 (4)
Finds	22	83

3.13 There were plans to introduce netting on the yards and replace the windows on the two main houseblocks, to prevent the ingress of drugs.

3.14 We considered that the prison had made no meaningful progress in this area.

Concern: There was insufficient oversight and accountability for custody officers, particularly in their use of force. The pervading culture among officers was not focused on responding to prisoner need and the delivery of effective support. Managers did not provide robust oversight to hold officers to account and we were, for example, told about very poor behaviour by some staff working in the segregation unit. Leaders had also failed to investigate serious concerns about the use of force against some prisoners.

3.15 Governance of use of force remained weak. Weekly scrutiny meetings had ended around two months before our visit, so senior leaders had not scrutinised more recent footage to establish whether use of force had been justified or proportionate.

3.16 The issue of staff not routinely drawing body-worn video cameras had not been addressed effectively, and we observed that most staff did not wear these. Two out of the three baton uses since the full inspection had not been captured on camera, so had not been scrutinised by senior leaders, and this had not been challenged.

3.17 Footage we were able to review showed that, when cameras had been used, they had often been activated too late to capture all relevant events leading up to the incident, or to establish any effective learning.

3.18 A large number of use of force statements was still outstanding, and some of those we saw were of poor quality, often lacking detail or not accurately reflecting incidents as seen on the footage. The limited quality assurance in place had not been effective.

3.19 There were credible plans to improve oversight of use of force, and a detailed action plan had been produced shortly before our visit. A full-time use of force coordinator had been appointed, scrutiny of footage was due to resume imminently and the use of cameras had been made mandatory for night staff. However, it was too soon to judge the impact of these changes.

3.20 We considered that the prison had made no meaningful progress in this area.

Concern: Too many prisoners were segregated for long periods without access to a decent and meaningful regime and there were no clear reintegration plans.

3.21 The use of segregation remained high and the unit was often operating at full capacity. Lengths of stay for some prisoners were too long, with one prisoner segregated for over 180 days with no clear plans to address his situation.

3.22 Despite more consistent staffing following the HMPPS step-in process, the regime for segregated prisoners remained too limited. They were permitted just 30 minutes' access to the fresh air, use of the unit electronic kiosk to make applications and access to a grubby shower each day. On-unit reading materials were very limited, with only around six books available at the time of our visit.

3.23 Access to other aspects of the prison regime on a risk-assessed basis was not considered. For example, local data indicated that no prisoners had asked to attend religious services over the last two quarters, and those we spoke to were not aware that that they could be considered for this, subject to risk assessment. More positively, since the last inspection, these prisoners were now able to collect their own meals from the servery.

3.24 Review boards to authorise continued segregation remained a concern. They were poorly attended and did not set meaningful targets (see below), and there was little evidence of actions taken, all of which

contributed to excessive periods of segregation. We reviewed the documentation of authority to segregate prisoners under Rule 45 (segregation for good order or their own protection) for those segregated in August 2023 and found that none had been completed to an acceptable standard. Documentation for the prisoners segregated at the time of our visit was also poor. Daily records were rarely used and few case notes were completed, other than from members of the chaplaincy and daily duty manager visits.

3.25 There was evidence that the practice of holding review boards at prisoners' cell doors had become more frequent. This was unacceptable as it did not offer sufficient privacy or give the prisoner the opportunity to contribute appropriately.

3.26 Behaviour targets to support reintegration planning were poor and did not address the issues that had led to the initial segregation. For example, a prisoner had been segregated in early November for a serious act of violence, but behaviour targets to support reintegration included 'keep a clean and tidy cell'.

3.27 In nearly all cases that we reviewed, the primary route of reintegration had been a transfer to another prison, but because of national population pressures, this was currently an unlikely option for most prisoners.

3.28 A range of segregation data was reviewed each quarter, but it was not clear how these were used to drive improvement and some of the data were not accurate. Minutes of the segregation management meeting, where the data were reviewed, lacked detail and did not show any identified actions to drive improvement and accountability.

3.29 Some improvements to reintegration planning had become more evident from late December and were welcome, but further understanding of the purpose of the plans was needed to make sure that prisoners received adequate support. As part of the step-in process, managers from other HMPPS prisons with experience in segregation had been deployed, and at the time of our visit there were early signs of improvement as they implemented more consistent structures and provided more support for staff.

3.30 We considered that the prison had made no meaningful progress in this area.

Safeguarding

Concern: The level of self-harm was high and had risen in recent months. Not enough was being done to support prisoners in crisis and those at risk of self-harm.

3.31 The number of self-inflicted deaths remained a concern. Since the full inspection, there had been two, which brought the total to five self-inflicted deaths in 2023. This included the death of a prisoner housed in the segregation unit, which had resulted in staff suspensions and the incident being subject to external investigation.

3.32 Despite the high number of deaths, oversight of the Prisons and Probation Ombudsman (PPO) recommendations following their investigations was weak. The establishment action plan did not clearly identify what the recommendations involved, or the actions taken and was not shared appropriately with other departments on-site. For example, the house block managers and safer custody team had not seen this plan; it was therefore not surprising to see similar themes emerge from subsequent PPO investigations.

3.33 Levels of self-harm remained high. In the six-month period before the last full inspection, the self-harm rate per 1,000 prisoners had been 344, and this had risen to 484 in the same period before the current visit – a 41% increase. There was insufficient analysis of data to understand the drivers of self-harm better, and no clear action plan to support a reduction.

3.34 The number of prisoners who continued to be segregated while subject to ACCT procedures was of concern, with up to nine at the time of our visit. Such high numbers made it difficult to provide the level of care needed to support the physical and mental well-being of these individuals.

3.35 Most prisoners we spoke to being supported by ACCT case management reported feeling cared for by staff. However, the quality of ACCT documentation did not reflect this care and we could not be confident that appropriate support was in place for those in crisis.

3.36 Some prisoners had been subject to long periods of constant supervision without being offered any purposeful activity or regime. There was still no oversight of the use of anti-ligature clothing and leaders were unable to tell us how many times it had been used, or for how long.

3.37 The frequent redeployment of the safer custody team had often left the department with skeletal staffing levels, which significantly impeded their ability to support key safety functions.

3.38 We considered that the prison had made no meaningful progress in this area.

Health, well-being and social care

Concern: Longstanding staff shortages in health care resulted in lengthy waits for services and some poor outcomes for patients. This was exacerbated by limited strategic support and a lack of governance over the service.

3.39 There had been an improvement in the recruitment of staff within all health care teams and the improved use of regular agency staff. However, because of the instability of the prison and concerns over the safety of health care staff, only key health services were being delivered. This situation had been ongoing since May 2023 and although local delivery board meetings had been re-established, they were not effective. There had also been additional emergency strategic meetings since September 2023 with prison senior leaders, NHS England and the health provider to try to resolve some of the difficulties, but chronic prison staff shortages and the volatility of the establishment had continued to have a negative impact on delivery.

3.40 Relationships between health care and prison staff continued to be strained, with ineffective communication resulting in some adverse outcomes for patients. We found several examples of the prison failing to arrange health care interventions; this included the cancellation of hospital appointments without consultation with health care staff, a lack of staff to facilitate reviews in the segregation unit and a failure to send out patients who needed urgent hospital treatment. Officer supervision of medicines administration queues was also inconsistent, which compromised patient confidentiality and created opportunities for diversion of medicines.

3.41 Some clinics in the health centre had continued and more were now being organised, but there had been high levels of non-attendance as a result of limited prison staffing and the restricted regime. There had been a reduction in the waiting time for psychological therapies, but this was still too long, at approximately 40 weeks; individuals waiting were written to every eight weeks, but there was limited support offered in the interim.

3.42 Face-to-face assessments for prisoners with substance misuse issues were limited, which posed clinical risk. On a few occasions, prisoners suspected to be under the influence of illicit substances had not been identified to health care staff by officers. This, and the restricted regime, meant that health care staff were sometimes unable to complete an assessment of their condition or offer any face-to-face harm minimisation advice and guidance.

3.43 The health care application process had improved and there was now a more robust system with daily clinical oversight, which meant that urgent need was prioritised. Patients could see a GP or advanced nurse practitioner for essential issues promptly. Positively, all prisoners eligible for COVID-19 and flu vaccinations had been offered these, with

good uptake due to the efficiency of health care staff and the officers on duty over the few days when this had been completed. There were still long waits to see some of the allied health professionals, such as the physiotherapist and podiatrist.

3.44 There was a good approach to reporting clinical incidents and the timeliness of investigations had improved, but more work was needed to enhance the quality of investigations and to capture lessons learnt.

3.45 The management of health complaints had improved. There were now robust systems to make sure that appropriate responses to patients were provided in good time, including action being taken swiftly to resolve patient concerns.

3.46 Several safeguarding concerns had been identified and reported by health care staff, but we were not confident that the prison was always taking appropriate actions to safeguard patients, or that the health provider was following up on some of these issues with the prison as robustly as they should be. This was of significant concern, as we had found similar safeguarding incidents at the last full inspection. Health care staff continued to feel that their clinical judgement was not respected or taken into consideration by some prison staff, which had created adverse outcomes for patients.

3.47 We considered that the prison had made no meaningful progress in this area.

Education, skills and work

This part of the report is written by Ofsted inspectors. Ofsted's thematic approach reflects the monitoring visit methodology used for further education and skills providers. The themes set out the main areas for improvement in the prison's previous inspection report or progress monitoring visit letter.

Theme 1: There were not enough places in education, skills and work for the population. Allocations took too long and were not informed by prisoners' career goals.

3.48 Leaders and managers now provided sufficient activity places for the population to be occupied purposely, using a range of full- and part-time places across the provision. However, there were too many wing cleaning jobs and around half of these prisoners had not taken qualifications to enable them to carry out their duties effectively. Around ninety per cent of prisoners were employed and senior leaders had advanced plans to allocate the remaining unemployed prisoners to an

activity imminently. Education provision had been closed for around eight weeks, except for a few days, as there were insufficient prison officers to provide safe supervision. Since step-in, the governor had taken decisive action to make improvements and prison officer numbers had increased, resulting in education provision being fully open.

3.49 Leaders and managers had changed the delivery model for English and mathematics courses from fixed start and end dates to a flexible enrolment pattern, allowing prisoners to join courses at any time. As a result, more prisoners were able to access classes than previously. Managers in education had recruited additional staff and were increasing the number of classes in English and mathematics to meet need.

3.50 The allocation process for work and wider prison activities was very effective and ensured that prisoners were deployed fairly and quickly. Education staff managed their own waiting lists, and these informed the allocation process. Very productive and well-attended weekly allocations board meetings reviewed existing and new prisoners' activity needs to make sure that they were fit for purpose. Managers and staff from a wide cross-section of the prison reviewed a range of information to inform their decisions, as well as the allocations process.

3.51 The allocations process was also informed by prisoners' careers information, advice and guidance (CIAG) outcomes. However, staff did not identify sufficiently well all prisoners' career goals, or their resettlement needs while serving their sentence. The CIAG adviser position had been made permanent and most prisoners had completed a personal learning plan.

3.52 Ofsted considered that the prison had made reasonable progress against this theme.

Theme 2: The education, skills and work curriculum was too narrow and lacked ambition. There was no reading strategy. Most accredited programmes were only available at level 1 and below. In work, prisoners could not acquire accredited qualifications.

3.53 Education leaders and managers had extended and broadened the education and vocational training curriculum, informed by a formal review of the population's needs. Prisoners could access a wide variety of accredited courses up to level 2. New accredited courses had been introduced, providing prisoners with more choice at different levels, which included media, English for speakers of other languages, textiles, painting and decorating, and industrial cleaning.

3.54 Prisoners had the opportunity to accredit their skills at work in horticulture and waste management. Advanced plans were in place to introduce a performing manufacturing operations qualification in the industry workshops. A major furniture manufacturer, which contracted work to the prison, planned to introduce a qualification to accredit

prisoners' skills. Prisoners who gained this qualification would be guaranteed a job interview on release from prison. A booklet recognising and recording employment-related skills had recently been introduced at work, but had yet to be fully embedded.

3.55 Education leaders and managers had developed a prison-wide reading strategy, but it was at an early stage of development. Staff had made sure that a very large proportion of prisoners had undergone an assessment to identify their initial needs. Prisoners identified as having low-level skills in English, at entry-level 2 or below, took a further in-depth reading assessment to identify their specific support needs. However, some prisoners had yet to complete these assessments, although education staff were focusing well on clearing the backlog.

3.56 Education leaders and managers had trained and deployed Shannon Trust mentors to support emergent readers. Most had completed a peer mentoring course to enhance their skills further. Advanced plans were in place to train more prisoners to be peer and Shannon Trust mentors.

3.57 Emergent readers relied solely on Shannon Trust mentors to develop their reading skills. In education, a specific course was planned to support emergent readers and complement and consolidate the work of the mentors. Teachers had undertaken training in phonics and an awareness raising session was planned for instructors in industry workshops. Reading corners in industry workshops were at an early stage of development. Reading journals had recently been implemented in education, but it was too early to measure their impact.

3.58 Ofsted considered that the prison had made reasonable progress against this theme.

Theme 3: Leaders did not make sure that prisoners with additional learning needs had the support they needed. In nearly all cases that identified an additional learning need, further detailed assessments had not taken place.

3.59 Education leaders and managers had ensured that a large proportion of the prison population had been screened to identify any learning difficulties or disabilities (LDD). Not all prisoners who required a more in-depth assessment had been screened. There were plans to recruit a neurodiversity manager to lead on provision across the prison for prisoners with LDD needs.

3.60 Education leaders and managers had provided external training for staff who conducted LDD assessments. This included a hidden disabilities accredited course. Teachers had received training which gave them the skills to plan and provide effective strategies to support prisoners' additional needs in the classroom. For example, in a mathematics class, a prisoner was provided with an egg timer so that they could indicate to the teacher when they needed a two-minute break. In an English class, a prisoner used overlays and fidget toys,

which helped to enhance their concentration levels. Prisoners reported that the support they received helped them to make progress and stay on their courses. Those with identified LDD performed as well as their peers in external exams in education, and a very large proportion achieved.

3.61 Shannon Trust mentors, as part of their training, learned how to recognise specific disabilities, and provide and signpost prisoners for additional support.

3.62 In industries, instructors did not receive information about prisoners' LDD needs or receive help to enable them to provide effective strategies to support these prisoners at work. We were told that there were plans to deploy more peer mentors in workshops, to provide support to prisoners.

3.63 Ofsted considered that the prison had made reasonable progress against this theme.

Rehabilitation and release planning

Concern: There were not enough opportunities for prisoners to complete offending behaviour work and other programmes aimed at reducing their risks.

3.64 At the time of the full inspection, the programmes provision had been undermined by the departure of most of the forensic psychology team. This, and the time it took to recruit to these roles, had had a significantly negative impact on the delivery of offending behaviour programmes.

3.65 A needs analysis had identified over 500 prisoners who needed an intervention, but only 30 prisoners had completed one in the last six months. The provision was therefore not sufficient and resulted in many prisoners being released from prison without receiving the relevant intervention.

3.66 A recruitment drive for the psychology team was under way and at the time of our visit two vacancies remained. Recent efforts had been made to increase the offering of programmes. Regular delivery of Kaizen (an intervention on violence) and New Me Strengths (for those with LDD) had restarted, with increased numbers on the Thinking Skills Programme too. This was expected to support plans to ramp up the number of prisoners completing offence-focused work.

3.67 A proposal had also been submitted to start delivery of the Kaizen – Intimate Partner Violence programme on a one-to-one basis. While this had not been approved yet, it would be a welcome initiative, as there were many prisoners at the establishment with a history of domestic violence.

3.68 We considered that the prison had made insufficient progress in this area.

Concern: Public protection processes were not robust. Too few prisoners had been assessed for their suitability to have contact with children. Managers did not have a comprehensive understanding of all emerging risks and could not therefore manage them effectively. Public protection and pre-release arrangements were not good enough.

3.69 All prisoners were now screened on arrival and those that met the threshold were referred to the public protection team for further assessment.

3.70 Improvement in screening had led to increased telephone monitoring. At the time of the last full inspection, only seven prisoners had been subject to monitoring, and this had increased to 34 at the time of our current visit. Due to resource constraints, however, there had been many periods where calls had not been monitored, which undermined the process. Furthermore, calls made in a foreign language were not translated, which was not acceptable.

3.71 Better oversight of new arrivals who presented an ongoing risk to children had resulted in many more prisoners having contact restrictions in place. The number had risen from 45 at the time of the full inspection to 116 currently. However, a full review of the remainder of the population had yet to be undertaken, which meant that some prisoners who should have had restrictions in place did not.

3.72 Annual reviews on child contact restrictions were not always held and, when they were, the rationale and decision-making process was very weak, with poor recording.

3.73 Some efforts had been made to reduce the risk associated with use of the in-cell text messaging service; for example, prisoners with restrictions or certain offences were not permitted access and those found to be abusing the system were removed. However, while we welcomed the potential of such innovative technology to support rehabilitation, the system remained open to abuse, and we could not be confident that sufficient safeguards were currently in place to address this.

3.74 The interdepartmental risk management team meeting was now discussing more high-risk releases, but it was not multidisciplinary and had limited contributions from other departments, and actions were often not tracked.

3.75 We considered that the prison had made insufficient progress in this area.

Section 4 Summary of judgements

A list of the HMI Prisons concerns and Ofsted themes followed up at this visit and the judgements made.

HMI Prisons concerns

The prison was not safe enough. Outcomes were being undermined by violence, the ready availability of illegal drugs and an inexperienced staff group who lacked the confidence to provide effective supervision and management.
No meaningful progress

The level of self-harm was high and had risen in recent months. Not enough was being done to support prisoners in crisis and those at risk of self-harm.
No meaningful progress

There was insufficient oversight and accountability for custody officers, particularly in their use of force. The pervading culture among officers was not focused on responding to prisoner need and the delivery of effective support. Managers did not provide robust oversight to hold officers to account and we were, for example, told about very poor behaviour by some staff working in the segregation unit. Leaders had also failed to investigate serious concerns about the use of force against some prisoners.
No meaningful progress

Too many prisoners were segregated for long periods without access to a decent and meaningful regime and there were no clear reintegration plans.
No meaningful progress

Longstanding staff shortages in health care resulted in lengthy waits for services and some poor outcomes for patients. This was exacerbated by limited strategic support and a lack of governance over the service.
No meaningful progress

There were not enough opportunities for prisoners to complete offending behaviour work and other programmes aimed at reducing their risks.
Insufficient progress

Public protection processes were not robust. Too few prisoners had been assessed for their suitability to have contact with children. Managers did not have a comprehensive understanding of all emerging risks and could not therefore manage them effectively. Public protection and pre-release arrangements were not good enough.
Insufficient progress

Ofsted themes

There were not enough places in education, skills and work for the population. Allocations took too long and were not informed by prisoners' career goals.
Reasonable progress

The education, skills and work curriculum was too narrow and lacked ambition. There was no reading strategy. Most accredited programmes were only available at level 1 and below. In work, prisoners could not acquire accredited qualifications.
Reasonable progress

Leaders did not make sure that prisoners with additional learning needs had the support they needed. In nearly all cases that identified an additional learning need, further detailed assessments had not taken place.
Reasonable progress

Appendix I About this report

HM Inspectorate of Prisons (HMI 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 visits 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.

Independent reviews of progress (IRPs) are designed to improve accountability to ministers about the progress prisons make in addressing HM Inspectorate of Prisons' concerns in between inspections. IRPs take place at the discretion of the Chief Inspector when a full inspection suggests the prison would benefit from additional scrutiny and focus on a limited number of the concerns raised at the inspection. IRPs do not therefore result in assessments against our healthy prison tests. HM Inspectorate of Prisons' healthy prison tests are safety, respect, purposeful activity and rehabilitation and release planning. For more information see our website: https://www.justiceinspectorates.gov.uk/hmiprisons/our-expectations/

The aims of IRPs are to:

- assess progress against selected priority and key concerns
- support improvement
- identify any emerging difficulties or lack of progress at an early stage
- assess the sufficiency of the leadership and management response to our concerns at the full inspection.

This report contains a summary from the Chief Inspector and a brief record of our findings in relation to each concern we have followed up. The reader may find it helpful to refer to the report of the full inspection, carried out in [MONTH, YEAR] for further detail on the original findings (available on our website at https://www.justiceinspectorates.gov.uk/hmiprisons/).

IRP methodology

IRPs are announced at least three months in advance and take place eight to 12 months after a full inspection. When we announce an IRP, we identify which concerns we intend to follow up (usually no more than 15). Depending on the concerns to be followed up, IRP visits may be conducted jointly with Ofsted (England), Estyn (Wales), the Care Quality Commission (see Glossary) and the General Pharmaceutical Council. This joint work ensures expert knowledge is deployed and avoids multiple inspection visits.

During our three-day visit, we collect a range of evidence about the progress in implementing each selected concern. Sources of evidence include observation, discussions with prisoners, staff and relevant third parties, documentation and data.

Each concern followed up by HMI Prisons during an IRP is given one of four progress judgements:

No meaningful progress
Managers had not yet formulated, resourced or begun to implement a realistic improvement plan to address this concern.

Insufficient progress
Managers had begun to implement a realistic improvement strategy to address this concern but the actions taken since our inspection had had not yet resulted in sufficient evidence of progress (for example, better and embedded systems and processes).

Reasonable progress
Managers were implementing a realistic improvement strategy to address this concern and there was evidence of progress (for example, better and embedded systems and processes) and/or early evidence of some improving outcomes for prisoners.

Good progress
Managers had implemented a realistic improvement strategy to address this concern and had delivered a clear improvement in outcomes for prisoners.

When Ofsted attends an IRP its methodology replicates the monitoring visits conducted in further education and skills provision. Each theme followed up by Ofsted is given one of three progress judgements.

Insufficient progress
Progress has been either slow or insubstantial or both, and the demonstrable impact on learners has been negligible.

Reasonable progress
Action taken by the provider is already having a beneficial impact on learners and improvements are sustainable and are based on the provider's thorough quality assurance procedures.

Significant progress
Progress has been rapid and is already having considerable beneficial impact on learners.

Ofsted’s approach to undertaking monitoring visits and the inspection methodology involved are set out in the *Further education and skills inspection handbook*, available at https://www.gov.uk/government/publications/education-inspection-framework.

Inspection team

This independent review of progress was carried out by:

Ian Dickens	Team leader
Nadia Syed	Inspector
Lindsay Jones	Inspector
Maureen Jamieson	Health and social care inspector
Lynn Glassup	Health and social care inspector
Jacob Foster	Care Quality Commission inspector
Sheila Willis	Lead Ofsted inspector
Chris Brooker	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

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.

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.

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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