



**HM INSPECTORATE OF PRISONS**

3<sup>rd</sup> Floor  
10 South Colonnade  
Canary Wharf  
London E14 4PU

Tel: 020 3334 0353

E-mail: [barbara.buchanan@hmiprisons.gsi.gov.uk](mailto:barbara.buchanan@hmiprisons.gsi.gov.uk)

**HM Chief Inspector of Prisons  
PETER CLARKE CVO OBE QPM**

Date: 11 June 2019

The Rt Hon David Gauke MP  
Justice Secretary  
Ministry of Justice  
9<sup>th</sup> floor  
102 Petty France  
London SW1H 9AJ

Dear Secretary of State

**Urgent Notification: HM Prison Bristol**

**Summary**

In accordance with the Protocol between HM Chief Inspector of Prisons and the Ministry of Justice (MoJ), I am writing to you to invoke the Urgent Notification (UN) process in respect of HM Prison Bristol.

An unannounced inspection of HMP Bristol between 20 May and 7 June 2019 identified numerous significant concerns about the treatment and conditions of prisoners. It was the latest in a series of disturbing inspections at the prison over the last six years. As required by the process, in this letter I will set out the key evidence underpinning my decision to invoke the UN process and the rationale for why I believe it is necessary. In addition, I attach a summary note which details all the main judgements from this inspection. The summary note is drawn from a similar document provided to the Governor at the end of the inspection last week. The Governor, the Prison Group Director and officials of the MoJ have been informed of my intention to invoke the UN process. I shall, as usual, publish a full inspection report in due course.

**What the UN process requires of HM Chief Inspector of Prisons**

A decision to invoke the UN process is determined by my judgement, informed by relevant factors during the inspection that, as set out in the Protocol between HM Chief Inspector and the MoJ may include:

- poor healthy prison test assessments (HMI Prisons’ inspection methodology is outlined in the HMI Prisons Inspection Framework);
- the pattern of the healthy prison test judgements;
- repeated poor assessments;
- the type of prison and the risks presented;
- the vulnerability of those detained;
- the failure to achieve recommendations;
- the Inspectorate’s confidence in the prison’s capacity for change and improvement.

The Protocol sets out that this letter will be placed in the public domain, and that the Secretary of State commits to respond publicly to the concerns raised within 28 calendar days. The response will explain how outcomes for prisoners in the institution will be improved in both the immediate and longer term.

### Inspections of HMP Bristol since 2013

We last inspected Bristol prison in March 2017, when we reported clear evidence of declining standards. Outcomes in safety and the provision of purposeful activity were poor and respect and rehabilitation and release planning were assessed as being not sufficiently good. We believed, though, that there might be grounds for cautious optimism and that there was a realistic prospect of improvement. I concluded my introduction to the 2017 inspection report with the following comments:

*“... progress was inevitably fragile, and if these and other improvements are to take hold, we believe it is essential that the energetic and committed leadership of HMP Bristol is allowed to build on the foundations it has laid. All too often, we see that changes in leadership have contributed to a lack of direction and a decline in performance. There is no reason why, with increases in staff numbers, well-directed investment and consistent leadership from the senior team, Bristol should not deliver better outcomes for prisoners in the future.”*

At this inspection, in May and June 2019, we found that our optimism of two years ago was misplaced. Despite improved staffing levels and some new investment, and the inclusion of HMP Bristol in HM Prison and Probation Service ‘special measures’, there had been no improvement in any of our four healthy prison tests. Moreover, we found that all seven criteria for the invoking an Urgent Notification were met.

Healthy prison assessments since 2013				
	Safety	Respect	Purposeful Activity	Resettlement and Rehabilitation
2019	1	2	1	2
2017	1	2	1	2
2014	2	2	2	2
2013	2	1	1	3

The chronic and seemingly intractable failings at Bristol have now been evident for the best part of a decade. Our inspection in 2010 was the last time we felt able to report positively on the prison. Since 2013, we have described outcomes for those detained as reasonably good on only one occasion and against only one test. The other 15 assessments we have made have described outcomes that were either not sufficiently good or poor. A fundamental responsibility of any prison is to keep prisoners safe. In this, HMP Bristol has sadly failed. We have now assessed outcomes in safety as poor for two consecutive inspections, and not sufficiently good for the two inspections prior to that. The prison's record in providing purposeful activity for the men held there, including training and education that may equip them to lead productive lives on release, is equally poor.

### **What this decline means for treatment and conditions**

Our experience is that at each prison where we have invoked the Urgent Notification process, we have found features particular to that establishment. While Bristol may not have reached the extreme lack of order and crisis seen in some prisons, it has demonstrably been in a state of drift and decline for many years. The treatment and conditions found by inspectors were such that invocation of the UN process became inevitable. My concerns are set out in broad terms in the attached summary documents, but the following areas are key findings:

- Bristol is a frontline local prison, receiving prisoners from the courts, many with vulnerabilities and often with no previous experience of prison. In light of this, we were disappointed to see first night arrangements had only improved marginally and that many of these improvements were only introduced during the course of the inspection.
- In our survey, nearly two-thirds of prisoners said they had felt unsafe at some point during their stay at the prison, with over a third feeling unsafe at the time of the inspection itself. Recorded violence, much of it serious, had increased since our last inspection and was much higher than the average for local prisons. We saw that there was a new violence reduction strategy, some good security initiatives and some very important work to combat illegal drugs, but some of this was poorly coordinated, not measured for effectiveness and not applied with sufficient rigour to give us the assurance it will be impactful or sustained. Despite the high levels of violence, there were no prisoners being managed under CSIP (the agreed casework approach to managing perpetrators and victims of violence), which meant that perpetrators were not being monitored and challenged and victims were not being supported.
- The use of segregation, the number of adjudications and use of force incidents were all high and, to a large extent, reflected the levels of violence in the prison. Most work to improve processes was very recent and untested. Work to incentivise prisoners was too new to assess its effectiveness, and the poor management of adjudications led to a situation where so many charges were not proceeded with

that it risked creating a culture of near impunity for those prisoners who behaved poorly. Of the 1,075 adjudications so far in 2019, only 400 had reached a conclusion.

- The rate of self-harm had increased since the last inspection and remained higher than most other local prisons. There had been two self-inflicted deaths since our last inspection, and significant recommendations made following Prisons and Probation Ombudsman investigations had not been implemented. An extraordinarily high number of prisoners – one in 10 – were identified as being at risk of suicide and self-harm and were being managed through assessment, care in custody and teamwork (ACCT) case management processes. We believe this was unmanageable. There was no effective strategy to reduce levels of self-harm and this was an indication of risk aversion rather than considered risk management. This was poor practice and potentially an impediment to care for those in crisis.
- We saw examples of very poor care for prisoners identified as being at risk of suicide and self-harm. One prisoner being managed on ACCT became very distressed one evening and smashed up his cell. Despite this, staff did not review his case that evening, nor was the level of observations on him increased. He was left overnight, and all the following day, in his damaged cell.
- Our confidence in the prison's competence to support those at risk of self-harm was severely undermined when we found that prisoners had been unable to telephone the Samaritans from their in-cell phones since 15 May 2019 because the prison had not kept the number topped up with credit.
- We were extremely concerned to find that a hotline for the family and friends of those in crisis, to call and report their concerns, had not been checked by staff at all for the two weeks before the inspection. When inspectors asked for records, staff retrieved 21 voicemail messages which required action. Three of the prisoners concerned had already been released from Bristol.
- When we last inspected we were concerned about the lack of care, particularly social care for some very vulnerable prisoners with physical disabilities. At this inspection, the social care arrangements were still completely inadequate, leaving several prisoners we observed with unmet care needs. One of these men had been at the prison since October 2018. He was not able to walk unaided. He had a wheelchair, but it did not fit through his cell door. His cell had no adjustments made and he spent most of his day lying in bed, with a urine bottle tucked under his sheets. A fellow prisoner helped him by getting his meals, making sure he had clean bedding and clothing and lifting him in and out of his cell, but this prisoner was neither trained nor supervised. An initial social care referral was made in December 2018. A care assessment was made during our inspection on 5 June.
- Most accommodation remained bleak and grubby with too many overcrowded cells. C and G wings were the poorest environments. There remained a substantial backlog of maintenance work, infestations of cockroaches were common and

many cells lacked sufficient basic furniture. A bulk order of new furniture had been placed in January 2019, but had still not arrived.

- There were currently sufficient activity places for all prisoners to engage in education, training or work for at least part of the day, yet only half had been allocated and of these on average only about half attended. Leaders and managers had not prioritised purposeful activity, were largely unaware of the poor attendance rates, and their expectations were too low, despite significant investment in education facilities. Classes were often cancelled. The quality of teaching, learning and assessment was weak: too many prisoners failed to make any progress, complete their course or gain any qualification or tangible outcome. Time out of cell for the many prisoners not allocated to activity was limited to around two hours each day, and during the working day we found just under a third of prisoners locked in their cells.
- Bristol prison has an important role to play in resettling and reintegrating the many prisoners it releases. About 80 prisoners were released from Bristol every month, but a staggering 47% were released homeless or into temporary accommodation, which did little to enhance their chances of rehabilitation.

### **Special measures**

HMPPS has clearly had its own concerns, placing Bristol in ‘special measures’ since our 2017 inspection. Despite repeated requests, the prison failed to provide us with any meaningful objectives, action plans or assessment of the impact of ‘special measures’. From the evidence we gathered, I can say that the full report on the 2019 inspection will acknowledge some developments, although we were yet to see these having any substantial or positive impact on outcomes for prisoners. For example, staffing has increased over the last year, so that, in theory at least, the prison now has sufficient staff. However, the regime is still unreliable and fragile. We did note some recent success in reducing illicit drug use. D wing was currently being refurbished and some showers in other wings had also been improved. We found there has been significant capital investment to support education, with an education and training block due to open in August, but unless there is a fundamental improvement in the leadership and management of education and training, a new facility in itself will not deliver improvements.

Taken together, these pockets of improvement, although welcome, are not sufficient to give me confidence that the prison’s chronic failures have been addressed. For instance, we were told that following the refurbishment of D wing, other wings would follow suit, but we were not shown evidence of any plans for ongoing investment, despite the poor and sometimes squalid living conditions we have reported for many years.

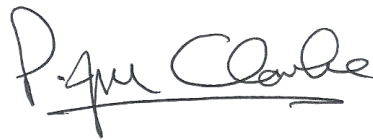
Implementing HMI Prisons’ recommendations – which we believe provide a pathway towards sustained improvement – has plainly not been a priority under ‘special measures’. It was telling, for example, that of the 76 recommendations we made in 2017, at this inspection we found that only 22 had been achieved in full. Incredibly, for a prison that has

been judged as unsafe in successive inspections, only one of the 11 recommendations made under 'safety' in 2017 had been fully achieved.

## **Conclusion**

Bristol is a busy and challenging local jail in a major city. In some inspections of similarly troubled prisons over the last 18 months, I have considered but chosen not to use the Urgent Notification process because I had some confidence in the prison's capacity for change and improvement, supported regionally and nationally where appropriate. As I have explained above, in 2017 I had grounds to think that the leadership at Bristol might be able to make some progress, called for them to be allowed to continue at Bristol, and expressed some cautious optimism. Two years later, there has been no significant improvement. My understanding is that 'special measures' are intended to provide support for the Governor of a struggling prison. If that is the intention, they have clearly failed at HMP Bristol. The investment which has taken place has not yet led to any tangible improvement in outcomes. Some of the efforts to improve have, in reality, been a case of too little, too late: some we saw had only just been implemented, and some were introduced during the inspection itself. On the basis of this latest inspection, I can have no confidence that HMP Bristol will achieve coherent, meaningful or sustained improvement in the future. For that reason, I have invoked the Urgent Notification process in the hope that your personal intervention will be able to bring about the much-needed changes.

Yours sincerely

A handwritten signature in black ink that reads "Peter Clarke". The signature is written in a cursive style with a horizontal line underneath the name.

**PETER CLARKE**



Debriefing paper by HM Inspectorate of Prisons

Full inspection of:

HMP Bristol

20, 21 May and 3-7 June 2019

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

# Contents

## Healthy prison assessments

1. Safety
2. Respect
3. Purposeful activity
4. Rehabilitation and release planning

DRAFT

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.



# Healthy prison assessments

---

Outcomes for prisoners are good against this healthy prison test.

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

Outcomes for prisoners are reasonably good against this healthy prison test.

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 against this healthy prison test.

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 against this healthy prison test.

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.

DRAFT

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

## 1. Safety

**Early days arrangements were undeveloped and prisoners received too little support. Too many prisoners felt unsafe, levels of violence were higher than in similar prisons, and higher than at the last inspection. Since our last inspection, a range of actions had been taken to make the prison safer but these were poorly coordinated and not measured for effectiveness. Use of segregation, adjudications and force were all high, and managerial oversight was lacking. Security arrangements were good. Actions to tackle drug use were very good and availability had reduced substantially. Levels of self-harm were very high and procedures to support those in crisis were weak. Outcomes for prisoners were poor.**

### Early days in custody

- Reception was cramped and remained ill-suited to the demands of a busy local prison.
- First night processes were relatively swift but not enough was done to allay prisoners' anxieties and help them settle in.
- A spacious first night interview area on D wing was opened during the inspection, but there was too little to engage or inform prisoners.
- First night safety interviews were not held in private and staff did not always follow the risk and needs assessment process, potentially missing important information.
- First night cells on C wing were grubby, bleak and poorly prepared. New arrivals had too little time out of cell or opportunity to associate.
- The first night experience on C3 for those prisoners needing substance misuse treatment located them in particularly impoverished conditions.
- New arrivals were routinely checked on their first night and saw a safer custody peer worker the next day.
- A basic induction to prison life took place most mornings. It was clear and useful, but prisoners without recent experience of Bristol were allowed to decline it.
- Induction to activities was not prioritised so it was difficult for new arrivals to access work and education.

### Managing behaviour

#### Encouraging positive behaviour

- In our survey, 62% of prisoners said they had felt unsafe at some time at Bristol and over a third said they currently felt unsafe.
- Levels of recorded violence, including serious assaults on both staff and prisoners, were much higher than the average for local prisons and had increased since our last inspection, although there had been some more positive data in recent months.
- The prison analysed a wide range of data to try to understand the causes of violence, but too much remained unexplained.
- Some impressive strategic initiatives had been introduced to make the prison safer - such as an effective new drug strategy, joint working with local and regional police

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

forces to reduce the threat posed by external gangs, and initiatives to reduce prisoner frustrations around living conditions. The prison responded well to emergent threats on a daily basis.

- The published safer prison strategy was well considered, but not all processes identified within it were undertaken and there was no dynamic action plan to measure effectiveness and inform future actions.
- Safer custody meetings were poorly attended and there was a lack of prison-wide ownership or understanding of safer custody processes, including the management of perpetrators and support for victims. Despite high levels of violence, no perpetrators of violence or victims were managed under CSIP arrangements (an agreed case work approach to managing perpetrators of violence and victims).
- A new IEP scheme had been recently introduced but it was too recent to assess its impact. There were still no behaviour improvement plans in place and reviews were too inconsistent to manage poor behaviour and reward good behaviour.
- There were few incentives for prisoners to be enhanced, and in our survey only 35% of prisoners said incentives and rewards encouraged them to behave well.

#### Segregation and adjudications

- The number of adjudications remained higher than in other local prisons. Too many were not proceeded with, remanded or referred and this undermined the challenge of poor behaviour.
- There was insufficient oversight of the adjudication process. Adjudication meetings were infrequent and poorly attended. Adjudication records were not always legible or quality assured.
- The number of prisoners segregated within the segregation unit was higher than in similar prisons and had doubled since the last inspection. In addition, too many prisoners were segregated on the wings where there was little managerial oversight.
- Living conditions in the segregation unit were generally good; some prisoners had TVs and radios and we observed some positive staff interactions with some challenging prisoners.
- Managerial oversight of segregation required improvement. All prisoners who arrived in the segregation unit were strip-searched without an appropriate risk assessment and recording of prisoners' behaviours and regime was poor. Reintegration planning had only been introduced in the last few weeks.

#### Use of force

- Use of force had increased since the last inspection and was high.
- Governance arrangements had only recently been implemented and by the time of our inspection there was too little information to identify trends and too little scrutiny to ensure full completion of documentation.
- Paperwork and body-worn camera footage we watched mostly demonstrated the appropriate use of de-escalation techniques and approved use of force methods. However, we observed one occasion where the use of special accommodation was not justified.

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

## Security

- Security processes continued to be proportionate to the risks posed and the establishment responded very well to the ongoing threat of drugs, organised crime and mobile phones. There was an appropriate focus on extremism and corruption prevention.
- A substantial amount of intelligence was analysed swiftly and a high proportion of searches were intelligence-led, which had resulted in finds of weapons, drugs and phones. However, as at the last inspection, too few suspicion drug tests were undertaken when required.
- Collaborative working with the local and regional police was impressive.
- In our survey, more than half the prisoner population said drugs were readily available. A significant amount of effort had been made to reduce drug use and there was evidence of some success, with the MDT positive rate having fallen from over 30% to 14% in the six months prior to the inspection. The previously high number of new psychoactive substance (NPS)-related medical emergencies had fallen by over a half and there had been no NPS positive drug tests for three months.

## Safeguarding

### Suicide and self-harm protection

- The rate of self-harm had increased since the last inspection and remained higher than at most other local prisons.
- There had been two self-inflicted deaths since the last inspection. Significant recommendations from the Prisons and Probation Ombudsman (PPO) had not been effectively implemented.
- Incidents of self-harm were not routinely investigated to understand the underlying causes.
- Although the safer custody team gathered some useful monthly data, this was not used to identify the latest challenges or develop an effective approach to reducing levels of self-harm.
- Some very poor living conditions and a lack of access to activities heightened the risk for prisoners in crisis.
- The number of open assessment, care in custody and teamwork (ACCT) documents remained very high, was much higher than at other local prisons, and was unmanageable. The instruction to health care staff to open an ACCT document routinely without applying their clinical judgement first was ill-advised. Over 10% of the population was receiving ACCT support during the inspection. This inevitably compromised the quality of care which could be delivered, and there was a real risk that staff had become inured to the most serious risks within this group.
- There had been good progress in training staff in suicide and self-harm prevention and work to develop the practice of ACCT case managers was underway.
- Constant supervision was used frequently but there were not enough appropriate cells to deliver this care effectively.
- The safer custody hotline, where family and friends could report their concerns about a prisoner's welfare, was not checked.
- Prisoners had been unable to call the Samaritans from their in-cell phones for several weeks prior to the inspection.

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

#### Protection of adults at risk

- Although the prison had some adult safeguarding processes in place, we still found vulnerable prisoners at real risk of exploitation living on wings without adequate support.

DRAFT

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

## 2. Respect

**Staff-prisoner relationships were mostly positive. Despite some improvements, wings remained grim and depressing and living conditions were poor for most. Prisoners disliked the food. Prison shop arrangements were good. General consultation arrangements were effective. Applications were not well managed. Some serious complaints were not responded to adequately. Despite recent improvements, equality and diversity arrangements remained weak and the needs of some minority groups were not being met. Faith provision was good. Health provision had improved and was good overall, although social care arrangements remained inadequate. Outcomes for prisoners were not sufficiently good.**

### **Staff-prisoner relationships**

- The chronic staff shortages we witnessed at our last inspection had now been addressed, although most staff had less than two years' experience.
- We saw some very skilful staff-prisoner engagement, especially when dealing with challenging prisoners, but we also often saw too many staff in wing offices.
- All prisoners had been allocated a key worker and the quality of interactions was good, but as yet too few sessions were taking place for the scheme to be fully effective.

### **Daily life**

#### **Living conditions**

- Most external areas were reasonably clean, but the grilles on cell windows were often filled with litter.
- One wing had been closed for complete refurbishment and there had been some investment to improve conditions on other wings, but living conditions for many prisoners were poor. C and G wings still offered the poorest environments.
- Communal areas and showers on most wings were in poor condition due to the deteriorating fabric of the buildings, and were noticeably grubby despite the large number of cleaners.
- Many cells were overcrowded. Most were bleak and run down although windows were generally in good repair. Many toilets had new lids and seats but most were still not adequately screened. Flooring was often damaged or missing altogether. Many observation panels were blocked and some were graffitied with offensive language.
- There were a substantial number of outstanding maintenance jobs during the inspection, many dating back to 2018.
- The need for a large amount of new furniture had been identified but a bulk order placed five months previously had not been fulfilled.
- Despite regular efforts to tackle infestation, cockroaches were commonplace.
- There was generally good access to toiletries and basic essentials.

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

#### Residential services (catering and shop)

- In our survey, only 20% of prisoners said the food was good, which was significantly lower than in similar prisons.
- Prisoners were given the option of a hot breakfast, which was positive. The lunch menu was very limited and had remained the same for over 12 months. The lunch and tea meals were served far too early.
- The food trollies used to transport meals from the kitchen were extremely dirty.
- Prisoner shop arrangements were good. There was an early days shop system which allowed new prisoners access to some canteen in their first 24 hours, and reduced the likelihood of debt.

#### Prisoner consultation, applications and redress

- There was a positive monthly consultation meeting in place with good attendance from around the establishment. The resulting 'you said – we did' action plan was effective and had showed some positive outcomes.
- In our survey, prisoners were very negative about the fairness and timeliness of applications. A recent review of the applications process had taken place, but management oversight and monitoring was still not sufficiently robust.
- Too many complaints were responded to late. Responses to general complaints were mostly good.
- Complaints against staff, including some serious allegations, were not always thoroughly investigated or addressed.

### **Equality, diversity and faith**

#### Strategic management

- There had been some recent improvements in the leadership and strategic oversight of equalities work, but this nonetheless remained weak. Until recently, equalities had not received sufficient senior management attention.
- Analysis of data was poor and where it showed disproportionate treatment of men in protected groups, the prison could not evidence what it had done to fully address this.
- Senior leads had been identified for the protected characteristic groups but were not yet driving action.
- Dedicated consultation for prisoners with protected characteristics was limited.
- As yet, there was little involvement from community groups which specialised in equality, although advanced plans were in place.
- Equality and diversity representatives were used well to offer support to the prisoner group, but did not attend equalities meetings.
- Most Disability Incident Reporting Forms (DIRFs) were responded to promptly, the quality of responses was good and internal quality assurance processes were robust.

#### Protected characteristics

- Around one-quarter of the population were identified as black and minority ethnic. Arrangements for them were good and our survey showed little disproportionality of treatment when compared to white prisoners.

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

- Support for Gypsy, Roma and Traveller prisoners and gay, bisexual and trans prisoners was good, but foreign national prisoners and young adults received little dedicated provision.
- There were significant gaps in the provision for prisoners with disabilities, and the needs of many prisoners with mobility issues were not being met (see also section on health, well-being and social care below). This situation had not improved since the last inspection. There was no effective prisoner carer system and some prisoners struggled with daily activities such as showering and were unable to access all areas of the prison. There were no care plans in residential areas and social care arrangements were very weak.

#### Faith and religion

- Faith provision was very good. The faith team was well integrated into the prison regime. There was good pastoral care and access to faith services had improved. Particularly good resettlement support was provided.

#### Health, well-being and social care

- Health provision had improved since our last inspection. Governance arrangements were strong, services were well led and an appropriate range of services were provided.
- Nurse-led triage on wing hubs worked well, but many of the treatment rooms were extremely poor environments. Specialist clinics were delivered from the main health care centre, but as a first-floor facility this limited entry for disabled patients. In addition, escorting and regime issues also periodically delayed general access.
- Medicine supply and administration on the wings was effective, but privacy was difficult to achieve and we were told officer supervision could be inconsistent.
- Arrangements to assess and deliver the social care needs of prisoners was inadequate. The prison had been without a social care provider for several years and without a provider available, insufficient measures had been put in place to ensure that prisoners' basic needs were being met (see also section on Equality, Diversity and Faith above).
- Dental provision was appropriate to need and a good service was offered.
- Mental health services were good with impressive urgent care arrangements and a range of appropriate therapeutic interventions provided.
- Substance misuse services had improved since our last inspection and were impressive, with strong partnership working and some emerging areas of good practice.
- The drug recovery landing on C wing remained squalid and degrading and did not support the well-being of prisoners attempting to detoxify.

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.



### **3. Purposeful activity**

**Many prisoners spent too long locked up during the working day. The regime was not reliably delivered. PE arrangements were reasonable but library provision was woeful. The leadership and management of education, skills and work activity remained inadequate. Too many prisoners were not engaged in any education, training or work. The provision did not adequately address prisoners' employability needs. Teaching and learning required improvement and too few prisoners made progress, or achieved their potential. Too many prisoners did not complete a course or gain a qualification. Outcomes for prisoners were poor.**

#### **Time out of cell**

- Time unlocked for those prisoners engaged in activities was around eight-and-a-half hours per day. For those not engaged in activities (around half the population) it could be as little as two-and-a-half hours.
- Evening association had been introduced for those actively engaging, but was not reliably delivered. There were regular delays and slippage in the regime.
- In our roll checks, we found 31% of prisoners locked up, which was much better than at our last inspection, but remained too high.

#### **Library and PE**

- PE facilities were reasonably good but a shortage of staff meant that facilities were not fully utilised.
- There was no analysis of attendance data and PE still interrupted work and learning for some.
- Support for prisoners with health and substance misuse needs was good.
- Accredited qualifications were still not being delivered.
- Pending the opening of a new library, attendance at the temporary library was exceptionally poor. Only 13 prisoners had been taken to the library from the wings in May. A very limited outreach service was provided.
- There had been no promotion of literacy during 2019.

#### **Education, skills and work activity**

Leadership and management of education, skills and work activity

- Plans for the provision in the new education and skills building (due to open in August) were ambitious and aimed to revitalise purposeful activity.
- Senior leaders and managers had made little progress in improving the quality of the provision since the previous inspection.
- Leaders and managers did not prioritise purposeful activity sufficiently. They did not have high enough expectations of what prisoners could achieve.
- The quality of the provision was not reviewed sufficiently to ensure that it improved rapidly and met prisoners' needs.

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

- Since the previous inspection, the provision had not been developed sufficiently to develop prisoners' employability skills.
- There were sufficient activity spaces for all prisoners to engage in education, training and work activities at least part-time, but only about half the population were allocated. Of those allocated, as few as 50% attended.
- Attendance was routinely interrupted by other regime activities and delays in the regime. Classes were often cancelled.
- There was insufficient oversight of the progress that prisoners made or whether they achieved their qualifications.
- The English and mathematics strategy was ineffective in ensuring that most prisoners improved their English and mathematical skills during their stay at the prison.
- Leaders and managers, including the education provider, did not use data effectively to challenge poor performance.
- There was insufficient accreditation of skills in workshops to meet prisoners' employment needs

#### Quality of teaching learning and assessment

- In a minority of the provision, prisoners made good progress.
- Teachers used oral questioning effectively to check on learning and to encourage participation in lessons.
- Teachers used information about the interests and behaviours of prisoners to improve the effectiveness of learning.
- Most prisoners who attended workshops focused effectively on completing their work and interacted well and productively with their peers.
- Most teachers and instructors did not make sufficient use of what prisoners already knew and could do to plan their individualised learning and training.
- Most prisoners' Individual Learning Plans (ILPs) were weak and did not help them to know what they needed to do to achieve qualifications or to make good progress towards them.
- Most teachers and instructors did not routinely provide clear feedback on how prisoners could improve their skills and understanding.

#### Personal development and behaviour

- Attendance at education, vocational training and industries was too low, and as a result too few prisoners accessed opportunities to increase their employability skills and plan for resettlement.
- Most prisoners were respectful and treated staff and each other with courtesy.
- The small numbers of prisoners in the print, bicycle mechanics, kitchens and prison café workshops took pride in what they produced. The quality of their work was usually of a high standard.
- In other workshops, planned activities were mechanical and repetitive, with the result that most prisoners had little interest or took pride in the work they were completing.
- Staff did not provide good enough information about the opportunities open to prisoners in education and vocational training in the prison.

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

- Arrangements were not yet fully effective in supporting prisoners to progress to education, training or employment upon release or transfer.

#### Achievements and outcomes for prisoners

- Outcomes for prisoners were poor.
- Too many prisoners who started their education courses did not complete them.
- The planning of the curriculum did not meet the length of stay or individual needs of prisoners.
- Prisoners did not make the progress of which they were capable or achieve their full potential. Too often, they were unable to progress to the next level of learning.
- The standard of prisoners' work was not good enough in the majority of areas.

DRAFT

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

## **4. Rehabilitation and release planning**

Arrangements to support prisoners' contact with family and friends had improved since the previous inspection and were reasonably good. Too many prisoners were without an up-to-date assessment of their risks and needs and many were transferred without an assessment informing their move. Offender supervisor contact was reasonably frequent. Some prisoners remained at Bristol for too long and were unable to progress or address their offending needs. Public protection arrangements were not sufficiently robust. Not all prisoners had their resettlement needs addressed on arrival. Only basic finance and debt advice was available. Despite strenuous efforts to address accommodation needs, far too many prisoners were released homeless or to temporary accommodation. Outcomes for prisoners were not sufficiently good.

### **Children, families and contact with the outside world**

- Prisoners experienced delays in receiving their mail.
- The provision of in-cell telephones enabled prisoners to maintain regular contact with family and friends, but there were still delays in activating accounts which caused some prisoners considerable distress.
- An improved range of family support and engagement was provided.
- Visits were well managed and visitors and prisoners were positive about their experience. The visits hall was dreary and required refurbishment.

### **Reducing risk, rehabilitation and progression**

- The reducing reoffending strategy was up-to-date and informed by a needs analysis, but this was fundamentally undermined by the lack of a dynamic action plan and wider prison involvement.
- From an offender management perspective, the prison held a challenging mix of prisoners: approximately one-quarter of the population was assessed as high or very high risk of harm and about 20% had been recalled to custody. Most prisoners stayed at the prison for less than three months, reflecting a significant churn in the population.
- Too many prisoners, about a third of those eligible, did not have an up-to-date OASys assessment of their risk and needs. Too many prisoners were transferred without an OASys assessment to inform their move.
- Offender supervisor contact had improved and was now reasonable.
- Most prisoners approved for home detention curfew were held beyond their eligibility date, usually because of a lack of accommodation.
- Too little work was undertaken to progress indeterminate sentence prisoners through their sentence.
- It was difficult for the prison to secure transfers for Category B prisoners so they stayed at the establishment for too long, which impacted on their ability to progress in their sentence.

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.

## **Public protection**

- Public protection procedures were not sufficiently robust.
- The risk management meeting was limited in both scope and attendance and did not consider imminent releases of high-risk prisoners to ensure that risks were being properly managed.
- However, there were good efforts to confirm prisoners' multi-agency public protection arrangements (MAPPA) management levels before release.
- Arrangements to assess prisoners on mail and telephone monitoring were reasonable, but there was a backlog of calls which had not been listened to, and systems to ensure day-to-day accuracy of all those being monitored were inadequate, and potentially put the public at risk.

## **Interventions**

- There were no interventions available to explore and address the offending behaviour of prisoners who stayed at the prison too long.
- There was some basic support to help prisoners manage their debts and open bank accounts, but there was no specialist advice available.
- Despite considerable efforts to address accommodation needs, far too many prisoners – about 47% – were released homeless or to temporary accommodation.

## **Release planning**

- About 80 prisoners were released from Bristol every month, so demand for resettlement planning was high.
- Not all prisoners were seen on arrival to have their immediate resettlement needs addressed. Needs were reviewed in most cases prior to release, but this was often too late to be fully effective.

This paper represents the material presented at the full inspection debrief by HM Inspectorate of Prisons. The material and assessments are indicative only, and may be changed at the discretion of the Chief Inspector after due reflection during the report production process or on the discovery of additional evidence. Inspected bodies will be offered the opportunity to correct factual inaccuracies as part of the publication process.