HM Chief Inspector of Prisons for England and Wales

Annual Report 2021–22

HC 411

HM Chief Inspector of Prisons for England and Wales

Annual Report 2021–22

For the period 1 April 2021 to 31 March 2022

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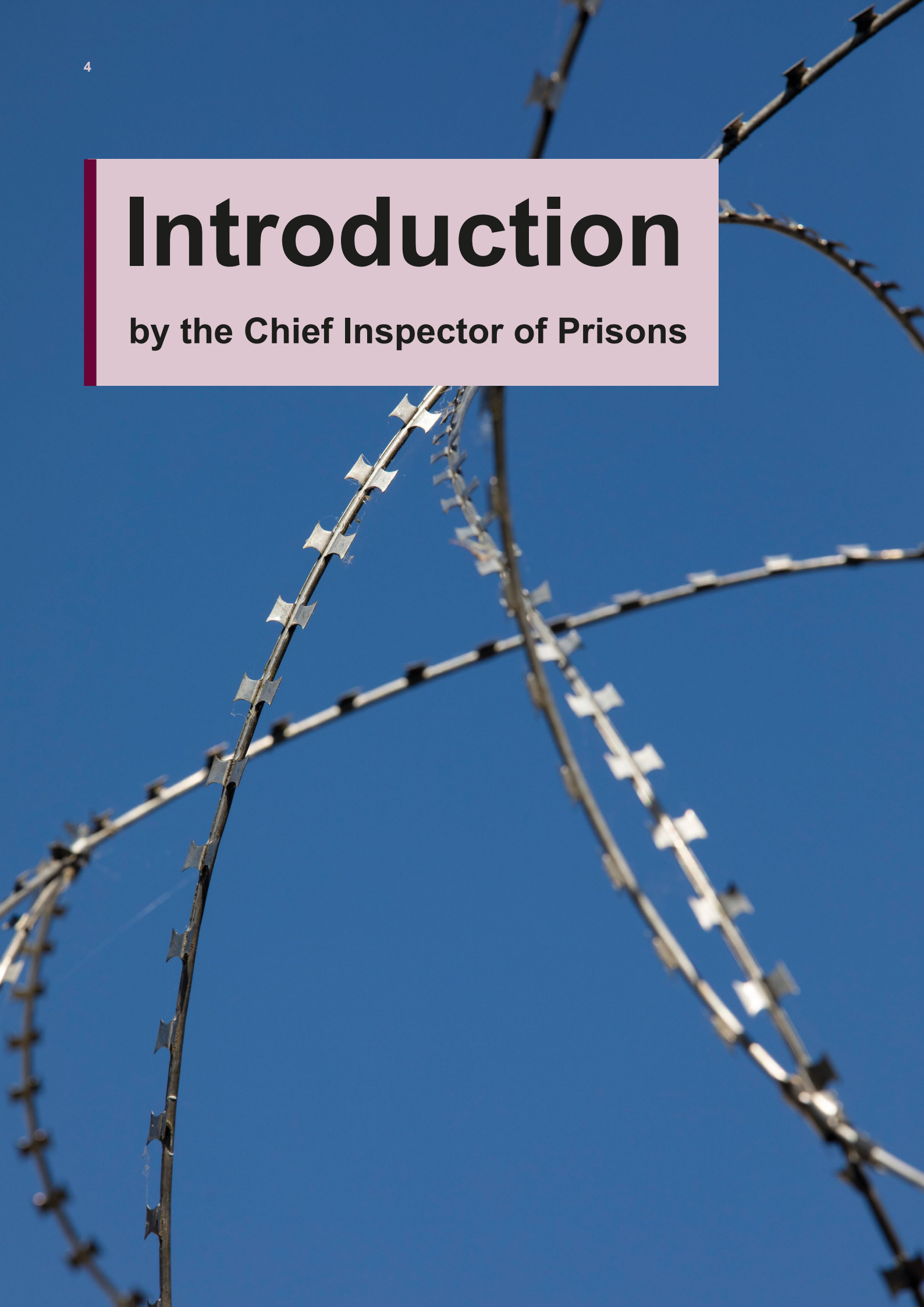
Introduction

by the Chief Inspector of Prisons



‘We have been struck by the long hours which many inmates have to spend locked in their cells in boredom. In several local prisons a proportion of the population, including unconvicted prisoners, were locked up for twenty-two hours or more each day, for weeks on end. In some training prisons, where a full working day was intended to be central to the life of the establishment, we found some of the population without any work and others employed on work which was unsatisfactory in nature or which was insufficient to support the number of prisoners allocated to it. We believe there are powerful reasons why Prison Department must ensure that an inmate does not spend day after day in blank inactivity; he should be kept occupied for a normal working day at work, education, or some other constructive activity.’

It is 40 years since this passage was published in the first annual report from HM Chief Inspector of Prisons and it remains as relevant now as it did in 1982. Each of my six predecessors has found a new form of words to describe this seemingly intractable problem.

In many of the prisons we visited since we resumed full inspections in May 2021, prisoners were locked up for even longer than they were in 1982: some for 23 hours a day or more. In category C training prisons, in spite of their remit, the situation was often little better, with prisoners spending their time sleeping or watching daytime television rather than engaged in the work, education or training that would help them to resettle successfully in the community on release. For many prisoners during COVID-19, the only available work was the desultory wiping down of wings with a damp cloth or leaning on a mop.

Throughout the year prisoners told us that their mental health was suffering, with 51% of men and 76% of women saying they had mental health difficulties. We do not yet know what the longer-term effect of lockdowns will be on prisoners, but there is no doubt that there will be a price to pay for the loss of family visits, the limited chance to socialise with other prisoners, the lack of education, training or work, the curtailing of rehabilitative programmes, the cancellation of group therapy and the dearth of opportunities for release on temporary licence (ROTL). In the last year, more prisoners than ever before will have left custody after spending almost their entire sentence locked in their cells – blank inactivity indeed.

Some of the most disheartening inspections were at prisons with large proportions of young men, where the often extensive grounds and workshops remained mostly empty and just a handful of prisoners were receiving any face-to-face teaching. The failure to fill the gaps in the skills and education of these prisoners and the low expectations of their abilities and potential meant they were learning to survive in prison rather being taught how to succeed when they were released. Unless these men are given the support that they need, there is the potential that they will lead long lives of criminality – creating victims, disrupting their communities and placing a huge burden on the state.

The lack of purposeful activity could, in part, be put down to the COVID-19 pandemic that continued to affect prisons across the country, particularly during the winter months where the arrival of the Omicron variant meant that all prisons were returned to stage 3 of the COVID-19 National Framework for Prison Regimes and Services. However, inspectors saw an increasingly wide variation in how individual prisons were interpreting guidance from both the prison service and Public Health England. There appeared to be no good reason why most prisoners at one category C training prison should have been locked up for 22 hours a day, while two-thirds of those at a category B local jail were out of their cells for five hours a day during the week.

There were similar differences in the youth estate. At two young offender institutions (YOIs) we found children had recently been allowed out of their rooms for up to six hours, while at another, where we conducted a scrutiny visit earlier in the year, children were unlocked for 10 hours a day. Similarly, at the two public sector YOIs, classroom education had only recently returned, while at Parc it had carried on throughout almost all of the pandemic. This was despite the historically low numbers in the youth prison population.

Restrictions often remained in place in prisons even where infection levels were low and many of the most vulnerable prisoners had been vaccinated. Overall there was not enough ambition from some governors or the prison service to restart activity. Those who wanted to move more quickly to get prisoners back into education were often hampered by the apparent reluctance of some providers to come back into prisons and begin face-to-face education. As time went on and restrictions began to lift, it was reasonable to expect prisons to be able to deliver more in this area. Yet, in conjunction with colleagues from Ofsted, we found a depressing picture of poor outcomes for prisoners and low purposeful activity scores.

The shocking findings of our joint thematic report with Ofsted into the teaching of reading were particularly depressing and demonstrated the lack of ambition for prison education. Inspectors found that that assessment of prisoners was inadequate, that teachers did not know how to teach prisoners to read, and that information was not being shared between prisons when prisoners moved. The teaching of reading was largely being left to Shannon Trust mentors, but this relied on prisoners being unlocked and suitable space found for the programme to continue. It is an astonishing failing that people can leave prison unable to read any more fluently than when they went in. The prison service must take urgent action to respond to our findings.

Too often we saw prisons fail to motivate prisoners to behave well. Those on the highest tier of incentives schemes frequently complained that they did not receive the rewards they had earned. For example, extra gym sessions for prisoners on an enhanced regime were cancelled because officers had been cross-deployed to other work. Some prison staff seemed to have forgotten one of the basic lessons of behaviour management – that giving a sought-after reward for good behaviour is a powerful way to motivate people. I have lost count of the number of times prisoners have told me that those who throw their weight around and make the most noise get what they want, while those who behave are ignored.

Similarly, if prisoners see that their peers are not sanctioned for poor behaviour, they understandably wonder why they themselves should be compliant. Yet we found widespread inconsistency in the way that rules were applied. There is no better way to undermine officers' legitimacy or erode standards than allowing people to be seen actively breaking the rules. If a rule matters, it should be enforced; if it does not, it should be abolished. Inconsistency is the enemy of a successful behaviour management system.

Perhaps the biggest challenge facing the prison service is recruiting enough staff and stemming the flow of resignations that have, in some jails, become a flood. As the economy began to open up after the lockdowns of 2020 and 2021, employment opportunities and wages grew, and prisons in more economically buoyant parts of the country found the pipeline of new officers drying up and increasing numbers leaving the service. This led to inexperienced officers supervising new recruits and meant that in jails with long-serving populations, prisoners knew much more about prison life than staff. Prison officers often told inspectors that their work had become monotonous and unfulfilling, consisting largely of unlocking doors and chivvying small numbers of prisoners into the exercise yard, the showers, the servery and then back into their cells, before opening up the next group. They said that under this constant pressure to maintain multiple regimes on one wing, relationships had become distant and transactional. They were not able to engage with prisoners or offer them the personal support that they needed. Many assaults on staff were precipitated by prisoners' frustration with not being able to complete daily tasks.

In some prisons, far too many officers leave within the first year, which suggests that in its haste to fill vacancies, HM Prison and Probation Service is not doing enough to filter out unsuitable candidates or make sure new recruits understand what the role entails. One governor told me that a new officer explained, as she handed in her notice, that her application form had been filled in by her mother.

Concerns for the well-being of women increase

We inspected five women's prisons using new **Expectations** that put greater focus on support for women, who are often themselves victims of exploitation and crime and may be suffering the effects of traumatic events in their lives. A large proportion of women experience poor mental health, and the pandemic restrictions were particularly difficult for this group. When we inspected one women's prison in May 2021, prisoners were still not allowed physical contact with their children. One woman told me she had taken the impossible decision not to see her son because she was unable to hug him. Thankfully this restriction on physical contact was lifted soon afterwards, but it clearly made it even more difficult to try to maintain normal family contact in an environment that already puts a strain on relationships.

We were very concerned to see acutely mentally unwell women being sent to prison due to a lack of community provision. We found profoundly distressed women in the health centre at Low Newton, where staff were doing their best to look after patients who should have been in hospital. In October 2021 I wrote to the Minister of State to advise her of this situation, noting my concerns that prison was not a suitable place of safety, and recommending that the prison service should begin to monitor the number of women entering custody through this route as a first step towards making sure that there was better provision in the community.

During the year, we published a short paper that highlighted some of the challenges we saw in women's prisons. Most concerning was the issuing of our lowest grade for safety at Foston Hall, where levels of self-harm were the highest in the women's estate and over 1,000 calls were being made to the Samaritans each month. However, restrictions in the women's prisons we inspected were less severe than in the men's estate and we were pleased to see a return to some pre-pandemic activity.

Finding suitable accommodation for women leaving prison remains a huge challenge, and the data produced by the Ministry of Justice seems to present a much more positive picture than we have seen on the ground. Resettlement planning was further hindered by the unification of the probation service, which had created uncertainty about future provision of resettlement services.

Children let down

Both of our joint inspections of secure training centres (STCs) with Ofsted resulted in Urgent Notifications being sent to the Secretary of State. At Rainsbrook, this was the second time we applied the process within a year, after the Youth Custody Service and the STC failed to make adequate progress. At both Rainsbrook and Oakhill, levels of violence were far too high, while expectations of children's behaviour were much too low, with insufficient boundaries. Leaders had failed to make sure that basic safeguarding processes were in place and staff were demoralised and often ineffectual. Both centres were suffering from difficulties with staffing levels: poorly led, inexperienced staff were leaving because the working environment was so challenging.

After the Urgent Notifications were issued, the Youth Custody Service removed all children from Rainsbrook and ended the contract with the provider. Meanwhile, a monitoring visit of Oakhill in January 2022 showed that there had been some progress in stabilising the centre. Girls from Rainsbrook who were refused placement in a secure children's home were transferred to Wetherby YOI, which opened a new female unit. Although this arrangement was not ideal, when we inspected Wetherby we found that the prison had put in place suitable provision and the girls told us they were getting better care in the YOI than they had done at the STC.

Wetherby generally remained a safer place than in recent years, but the Keppel unit, designed for the most vulnerable children, had lost its way and was operating as little more than another wing of the YOI. We found a much more worrying picture at Cookham Wood YOI, with very high levels of violence between the boys and towards staff. The YOI was failing to keep cells well maintained, clean and free of graffiti, despite having some of the newest accommodation in the youth estate.

Haphazard immigration arrangements on the south coast

The number of detainees in immigration detention began to rise throughout the year. Our scrutiny visit to one immigration removal centre (IRC) and full inspection of another showed that the centres were doing a reasonable job in providing for detainees, although some bleak, prison-like buildings did not contribute to a positive environment. The disengagement from Home Office staff both in IRCs and in prisons with high numbers of foreign national offenders meant that detainees spent longer in custody than needed, and were left anxious and uncertain about the future. Those who had been assessed as needing community support for mental health difficulties continued to be kept in custody.

I remain very concerned about the haphazard arrangements in place for those who have crossed the Channel in small boats. Promised facilities in Dover had not materialised when we inspected in November 2021, and we found that some families were sleeping on the floor in flimsy tents with inadequate bedding or crammed into facilities where some basic safeguards were not in place. With the recent increases in small boat arrivals, we have seen insufficient preparation to provide for vulnerable adults and children. Given the difficulties in maintaining adequate provision for new arrivals, we will be looking to see significant improvements at the new facility at MOD Manston.

A mixed picture in court custody

Our inspections of court custody this year reported on dirty cells that frequently contained graffiti and possible ligature points. The care by individual staff in court custody continued to be impressive where, in a busy and often bleak subterranean environment, they did their best to make sure detainees got the help they needed. Many staff members had some understanding of basic safeguarding for the most vulnerable detainees, but we were concerned that services were inadequate for detainees who did not speak English.

The new Prisoner Escort Custody Services contract meant that children were brought to and from court in much more suitable vehicles – a significant improvement. Staff shortages in London, however, meant that children in court custody did not get the attention and support they required. Too many women were still being transferred from court in cellular vehicles with men.

Looking to next year – the importance of leadership and ambition

The pandemic has led to a reduction in governor autonomy and some of the most ambitious leaders have been frustrated by the restrictions they face. Effective leaders have managed to make progress despite the many difficulties that the pandemic has caused. The high turnover of governors in public sector prisons has had the effect of stalling some of the more profound, necessary cultural change. The challenge for the prison service is to make sure that it identifies talent and promotes the most capable to leadership positions.

Since I came into post in November 2020, there has been much talk within the prison service of new regimes that will build on the learning from the pandemic. Although it is not yet clear what these will entail, there is the suggestion that prisoners may continue to be unlocked in smaller groups, with the aim of maintaining the reduced levels of violence that occurred during the pandemic. The risk is that prisoners will continue to remain behind their doors for much longer than in the past.

A look at the data over the last 20 years shows that more time spent behind a cell door does not actually result in lower levels of violence. For the first decade of the century, prisoners were unlocked for much longer than they are now, yet levels of violence were substantially lower. Although the rate of assaults fell by 37% to 239 incidents per 1,000 prisons in the 12 months to March 2021, the effect of lockdown on reducing violence should not be overstated as this was still a far higher rate than a decade ago.

The welcome lifting of all national prison restrictions on 9 May 2022 means that there is now no reason why prisons cannot return to regimes at least as open as they were before the pandemic. There is the chance to reset after a difficult two years. If prisons are to be an essential component of a successful justice system that is trusted by the public to keep them safe, the ambition must also be to go further, making sure that governors and education providers create opportunities for prisoners to develop vital skills that they can use when they return to the community. A new drive to increase release on temporary licence is essential, so that prisoners have the chance to experience a more normal working life that will help them to resettle successfully on release.

In a year's time, it would be refreshing not to have to repeat the Chief Inspector's stark words from 1982.

Acknowledgements

I would like to pay tribute to the staff of HM Inspectorate of Prisons who have continued to work with such dedication and professionalism over the last year. I also want to acknowledge the work of governors, directors, officers and other prison, immigration removal centre, custody and third sector staff who have continued to keep the service going in spite of the difficulties caused by COVID-19.

Charlie Taylor
Chief Inspector of Prisons

Who we are and what we do

Our purpose

To ensure independent inspection of places of detention, report on conditions and treatment, and promote positive outcomes for those detained and the public.

Our remit

Our remit is primarily set out in sections 5A and 43 of the Prison Act 1952 (as amended). We inspect:

- adult men's and women's prisons in England and Wales
- young offender institutions (YOIs) in England and Wales
- secure training centres (STCs) in England
- court custody in England and Wales
- all forms of immigration detention throughout the UK and overseas escorts.

Most inspections benefit from the assistance of other inspectorates, and inspections of STCs are undertaken jointly with Ofsted and the Care Quality Commission.

We also carry out inspections of other facilities by invitation, such as inspections of military detention facilities including the Military Corrective Training Centre and Service Custody Facilities in the UK, prisons in Northern Ireland (on behalf of Criminal Justice Inspection Northern Ireland), prisons on the Isle of Man and Channel Islands, and some other overseas prisons in jurisdictions with links to the UK.

Our approach

In usual circumstances, HM Inspectorate of Prisons carries out full inspections against published inspection criteria known as **Expectations** (see page 14). From April 2020 to April 2021, we temporarily amended our methodology for health and safety reasons in response to the COVID-19 pandemic. During this period, we introduced two new methodologies – short scrutiny visits and then more in-depth scrutiny visits (SVs) from August 2020. These methodologies allowed HMI Prisons to continue to provide effective scrutiny of places of detention while also minimising the risk of spreading infection. The number of inspectors on site and the time that they spent there were considerably reduced. Inspectors did not assess establishments against our full **Expectations** but instead considered a number of key areas. We resumed full inspections and use of the **Expectations** methodology in May 2021.

Expectations

Inspections consider outcomes for detainees. The Inspectorate's **Expectations** are based on and referenced against international and regional human rights standards, with the aim of promoting treatment and conditions in detention which at least meet recognised human rights standards.

Expectations for inspections of adult men's and women's prisons and YOIs are based on four tests of a healthy establishment. For men's prisons, the four tests are:

- **Safety** – prisoners, particularly the most vulnerable, are held safely.
- **Respect** – prisoners are treated with respect for their human dignity.
- **Purposeful activity** – prisoners are able, and expected, to engage in activity that is likely to benefit them.
- **Rehabilitation and release planning** – prisoners are supported to maintain and develop relationships with their family and friends. Prisoners are helped to reduce their likelihood of reoffending and their risk of harm is managed effectively. Prisoners are prepared for their release into the community.

The tests for women's prisons and YOIs vary slightly. The tests for immigration detention facilities are similar but consider the specific circumstances applying to detainees, that they are not being held for committing a criminal offence and that their detention may not have been as a result of a judicial process.

In other inspection sectors, the principles underpinning the healthy establishment concept are applied but the specific focus varies, depending on the sector.

Each expectation describes the standard of treatment and conditions an establishment is expected to achieve. These are underpinned by a series of 'indicators', which describe evidence that may show the expectation being met. The list of indicators is not exhaustive and does not exclude other ways of achieving the expectation.

The inspection team assesses the establishment's performance against the healthy establishment tests using the following judgements:

Numeric	Definition
4	**Outcomes for prisoners/detainees are good** There is no evidence that outcomes for detainees are being adversely affected in any significant areas.
3	**Outcomes for prisoners/detainees are reasonably good** There is evidence of adverse outcomes for detainees in only a small number of areas. For the majority, there are no significant concerns.
2	**Outcomes for prisoners/detainees are not sufficiently good** There is evidence that outcomes for detainees are being adversely affected in many areas or particularly in those areas of greatest importance to the well-being of detainees. Problems/concerns, if left unattended, are likely to become areas of serious concern.
1	**Outcomes for prisoners/detainees are poor** There is evidence that the outcomes for detainees are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for detainees. Immediate remedial action is required.

Inspectors use five key sources of evidence in making their assessments:

Observation

Prisoner/detainee surveys

Discussions with prisoners/detainees

Discussions with staff and relevant third parties

Documentation

HMI Prisons usually operates an almost entirely unannounced inspection programme (other than in exceptional circumstances), with all inspections following up recommendations/concerns from the previous inspection. There is a minimum frequency for inspection of all types of establishments, with the timing of inspections deliberately unpredictable. Such an approach is based on, and responsive to, considered intelligence and proactive risk assessment.

We generally inspect prisons at least once every five years, although we expect to inspect most every two to three years. Some high-risk establishments may be inspected more frequently, including those holding children, which are currently inspected annually.

We also usually conduct independent reviews of progress (IRPs), short follow-up visits to about 20 prisons a year. They aim to provide independent evidence about how much progress has been made in improving the treatment and conditions for prisoners following our recommendations/concerns from previous inspections.

Every immigration removal centre (IRC) also usually receives a full unannounced inspection at least once every four years, or every two years if it holds children. Non-residential short-term holding facilities (STHFs) are inspected at least once every six years. Residential STHFs are inspected at least once every four years. Within this framework, all immigration inspections are scheduled on a risk-assessed basis.

We inspect court custody facilities at least once every six years.

In addition to inspections of individual establishments, we produce thematic reports on cross-cutting issues, singly or with other inspectorates, including as part of the Criminal Justice Joint Inspection process. We also use our inspection findings to make observations and recommendations relating to proposed legislative and policy changes.

OPCAT and the National Preventive Mechanism

All inspections carried out by HM Inspectorate of Prisons contribute to the UK's response to its international obligations under the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). OPCAT requires that all places of detention are visited regularly by independent bodies – known as the National Preventive Mechanism (NPM) – which monitor the treatment of and conditions for detainees.

One

The year in brief

Between 1 April 2021 and 31 March 2022 we published 63 inspection, scrutiny visit and thematic reports.

Adult prisons (England and Wales)

- Inspections of 19 prisons holding adult men
- Inspections of five prisons holding adult women

Establishments holding children and young people

- Inspections of two young offender institutions (YOIs) holding children under the age of 18
- Three inspections of two secure training centres (STCs) holding children aged 12 to 18, jointly with Ofsted, with two further monitoring visits to one STC

Immigration detention

- Inspection of one immigration removal centre (IRC)
- Inspection of detention of migrants arriving by small boats
- Inspection of three residential short-term holding facilities (STHFs)
- Inspection of two overseas charter flight removals to three European countries

Police custody

- Inspection of police custody suites in four force areas, with HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS)

Court custody

- Inspection of two court custody areas

Scrutiny visits

- 14 reports covering visits to 10 adult men's prisons, two women's prisons, one YOI and one IRC

Extra-jurisdiction inspection

- One prison in Northern Ireland

Other publications

In 2021–22, we published the following additional publications:

- **Prison education: a review of reading education in prisons** (jointly with Ofsted)
- **Focus on women's prisons. A briefing paper**
- **Expectations: Criteria for assessing the treatment of and conditions for women in prison**, Version 2 (April 2021, updated July 2021)
- **Neurodiversity in the criminal justice system: A review of evidence** (jointly with HMI Probation and HMICFRS)
- **A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders** (Criminal Justice Joint Inspection)
- **Contingency asylum accommodation: Penally Camp and Napier Barracks** (jointly with the Independent Chief Inspector of Borders and Immigration)

During the year we issued three Urgent Notification letters to the Justice Secretary expressing our serious concerns immediately following an inspection of a prison/STC.

We also made written submissions to a range of consultations and inquiries, commented on draft Detention Services Orders and gave oral evidence to Parliamentary committees.

Written submissions

- Department of Health and Social Care, Reforming the Mental Health Act (April 2021)
- Home Office, Detention Services Order, Rule 40 and 42 (April 2021)
- All-Party Parliamentary Group on Women in the Penal System, Women's health and well-being in prisons (May 2021)
- Home Affairs Committee, Violence against women and girls (May 2021)
- Her Majesty's Prison and Probation Service (HMPPS), NHS England and NHS Improvement, National Women's Prisons Health and Social Care Review (May 2021)
- Justice Select Committee, Mental health in prison (June 2021)
- Justice Select Committee, Women in prison (June 2021)
- Home Office, Detention Services Order 09/2012, Searching policy (July 2021)
- HMPPS, Managing separation in the children and young people secure estate (July 2021) – joint National Preventive Mechanism submission
- HMPPS, Certified Prisoner Accommodation Framework (September 2021)

- Public Accounts Committee, Reducing the backlog in criminal courts (November 2021) – joint Criminal Justice Joint Inspection submission
- Ministry of Justice, Delivering justice for victims: A consultation on improving victims' experiences of the justice system (February 2022) – joint Criminal Justice Joint Inspection submission
- Home Office, Detention Services Order, Assessment, Care in Detention and Teamwork (February 2022)
- National Institute for Care and Health Excellence, Self-harm: assessment, management and preventing recurrence (March 2022)

Oral evidence

- Justice Select Committee, Women in prison (19 October 2021)
- All-Party Parliamentary Group on Women in the Penal System, Women's health and well-being in prisons (26 October 2021)
- Justice Select Committee, Mental health in the criminal justice system (8 March 2022)

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Go to: **https://twitter.com/HMIPrisonsnews** or @HMIPrisonsnews

Two

Scrutiny visits

At the start of this reporting year, we continued our programme of scrutiny visits (SVs), introduced in August 2020 to examine conditions for prisoners during the pandemic and consider how well establishments were recovering. We published 14 SV reports, which took place at 10 men's prisons, two women's prisons, one young offender institution and one immigration removal centre. SVs continued until May 2021, when we were able to return to full inspections.

Inconsistent provision

Our SVs to adult prisons highlighted inconsistency in the provision of services; for example, the Listener service – where prisoners trained by the Samaritans provide confidential emotional support to their peers – varied from a complete halt at Bedford to some ongoing provision at Bure and good access at Thorn Cross. Given the effects of the pandemic on prisoners' well-being, it was unacceptable that not all had access to this important support.

Our SVs continued to identify much reduced purposeful activity and wide variations between what prisons offered. Libraries were closed in almost all prisons and, while most provided a substitute service to make sure that prisoners could have books and DVDs, several failed to offer adequate alternatives or were slow to reopen as community restrictions eased. This left prisoners without resources to combat the boredom and isolation of the extended periods they spent locked in their cells. There was, however, some innovative practice; for example, at Sudbury, the library service had developed a 'share a story' project, where the prisoner and his child were sent the same book that they could then read together over the phone.

In many prisons, the chaplaincy had continued to offer innovative pastoral support and opportunities for worship when corporate services were suspended. This included helping prisoners to maintain contact with their family through computer tablets at times of birth or death and visiting those who were in crisis. We often found variation in the speed at which corporate worship had been re-established.

Impact of the restrictions on new arrivals

Restrictions had a particular impact on those new to the prison. Ford, for example, had suspended the induction process and, until the week before our visit, new prisoners had to rely entirely on their peers to give them the information they needed, leaving them isolated and poorly informed. By contrast, peer workers at Bure provided up-to-date information and explained life under the COVID-19 restrictions, while new arrivals at North Sea Camp were given a comprehensive induction booklet, which prisoners said contained all the information they needed.

Open prisons

Five of the SVs took place at category D open prisons. These jails should prepare prisoners for resettlement and release, giving them opportunities to spend time at home and work outside the prison. Disappointingly, we found prisoners were experiencing many of the barriers they had faced in closed prisons, which were affecting their mood and mental health, and sometimes their relationships with staff. At Sudbury, for example, poor staff-prisoner relationships had undermined the prison's rehabilitative culture. These problems were likely to be further affected by the reluctance of some prison leaders to open the regime, even as restrictions in the community eased.

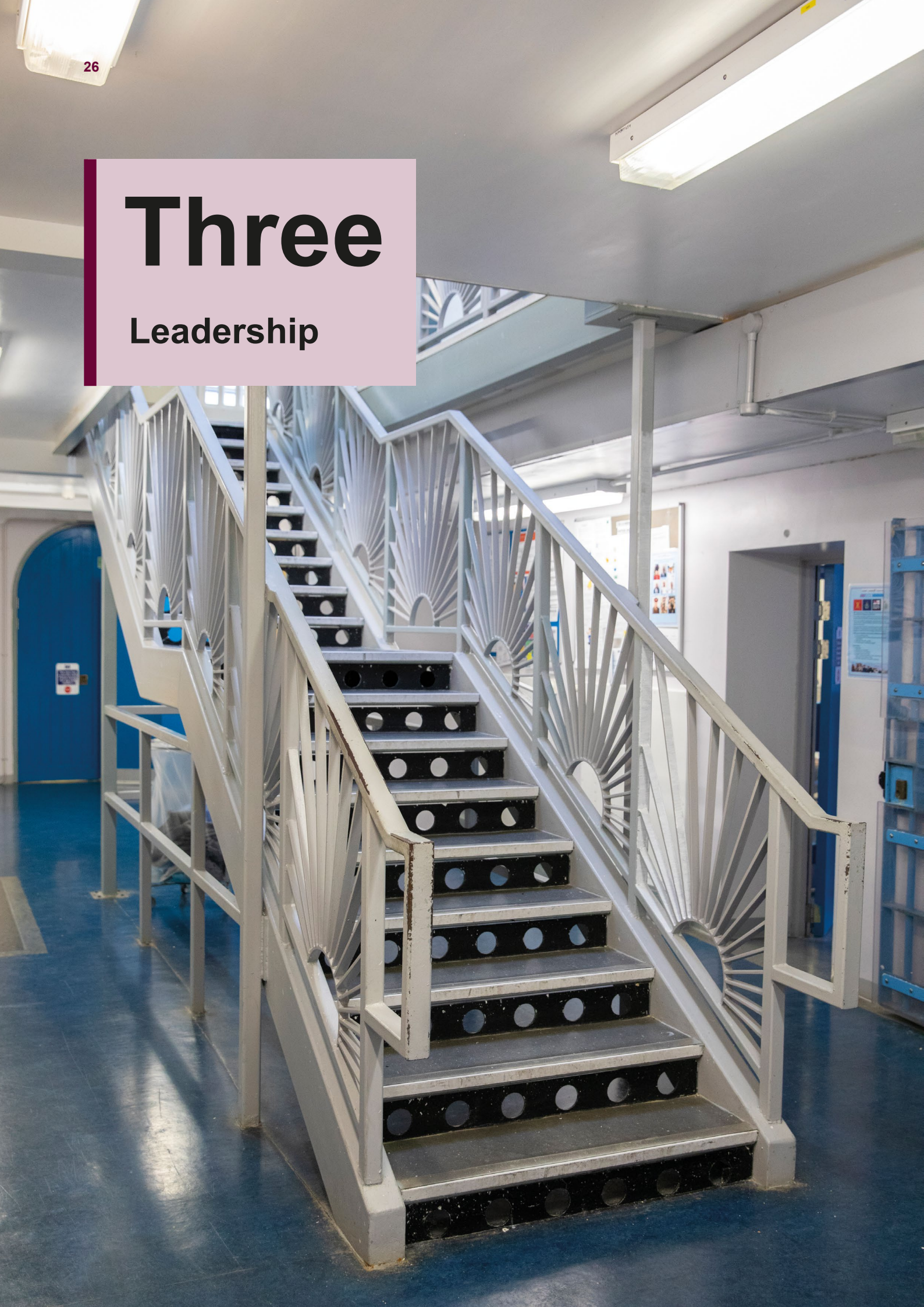
While some open prisons maintained the routine of fully unlocking prisoners, with Leyhill giving them 11 hours a day out of cell, others, such as North Sea Camp, only let them out of their residential units for an hour a day. Although time out of cell was inevitably better than in the closed estate, it was difficult to understand why some open prisons had imposed excessively restrictive regimes.

The suspension of release on temporary licence (ROTL) at the beginning of the pandemic had prevented prisoners from being released into the community to work or maintain contact with their families. This was lifted in July 2020, but prisons were inconsistent in how quickly they implemented the changes. While Thorn Cross was quick to send prisoners who qualified as essential workers out on ROTL, Leyhill had made no such releases until December 2020. For most held in category D prisons, the suspension of ROTL had prevented their progression and affected their resettlement opportunities and the maintenance of family ties.

The restrictions also had an impact on offender management work, preventing some individuals from being able to demonstrate to the Parole Board that they were able to go into the community safely. Too often we found that prison leaders did not have a plan to reinstate rehabilitative provision or were slow to respond to prisoner concerns about their progress.

Three

Leadership



In July 2021, we introduced new leadership expectations to our inspection methodology for adult men's prisons, women's prisons and young offender institutions.

We have always reported on leadership in our commentary on the four healthy prison tests and in the Chief Inspector's introduction to reports, but to make our judgments more consistent and prominent, we devised four specific expectations setting out the leadership practices which enable establishments to perform well, covering:

- direction
- engagement
- enabling
- continuous improvement.

Following a short pilot, we introduced the new expectations in our report on Downview in July 2021. Since then, we have identified several emerging themes.

Good leadership gets results

We consistently saw that where leaders had a good understanding of their prisons, made use of appropriate data and created plans that were clear, measurable and well communicated to staff and prisoners, jails tended to be better organised, safer and had higher general standards. At prisons such as Send, Manchester, Feltham, Bedford, Oakwood and Altcourse we saw the effect of strong leaders with high expectations making progress in what was a very difficult year.

Leading through a national pandemic

Leaders and staff had worked exceptionally hard to manage COVID-19 in prisons. HMPPS, in partnership with local health providers and Public Health England, took swift action to reduce the impact of the inevitable spread of infection. Although, sadly, some prisoners and staff lost their lives to COVID-19, the rate of deaths was far lower than projected at the start of the pandemic. As key workers, most prison leaders and staff continued to provide an invaluable service on the frontline, despite the risk to their own safety.

Restricted regimes

Throughout this reporting year, prisons remained in 'command' mode, which meant that governors were taking instructions from HMPPS to provide assurance of safety and consistency across the estate. As the pandemic took hold in the community, HMPPS leaders imposed a framework of restrictions and a recovery plan (see Glossary) setting out four regime stages with restrictions gradually easing at each one. The regime stage was determined by several factors, including infection rates and staffing levels. The national framework restricted the ability of governors to assess their own risks and determine the type of regime they could deliver, and led to prisoners locked in their cells for much longer than usual.

> Prisoners repeatedly told us of being locked up for more than 23 hours a day in the weeks leading to the inspection – some had as little as 45 minutes a day out of their cell. The regime was inadequate, and it was almost impossible for prisoners to get a shower, use the electronic kiosks and manage their day-to-day needs in the very limited time unlocked. **Wandsworth**

Staffing

The restrictions on time out of cell were determined not only by COVID-19 safety procedures set out in the national framework, but by unprecedented staff shortfalls. Factors contributing to this included frequent staff absences due to infection or track-and-trace procedures and major challenges to recruitment and retention. In addition, the allocation of staff based on full regimes no longer fitted the requirements of the restrictions – for example, more staff were now required on residential units to facilitate the unlocking of prisoners in smaller groups. This resulted in staff being redeployed from specialist areas to cover unfamiliar tasks while other important work was neglected (see below). In many prisons we visited, regimes were being run with some very inexperienced staff. While most prisons had dedicated some resources to mentoring, they were unable to provide new staff with all the support, challenge and development they needed.

> A lack of accountability and management oversight of staff had enabled poor practice to go unchallenged… Staff coaching and training had been neglected during the COVID-19 restrictions, even though almost a third of officers had less than two years in post. **Chelmsford**

Staff shortfalls and less prisoner time out of cell placed a monumental pressure on the ability of staff to build positive and constructive relationships with prisoners. Coupled with the lack of effective key work, few new staff had been able to fulfil the full rehabilitative role of a prison officer. The findings from our staff survey revealed that the majority of respondents who were frontline operational staff had low or very low morale at work.

> "I have been in the job six years now and I have never seen staff morale so low and this is really difficult to see… I like the job of being a prison officer, however it is really testing me and making me question whether this is for me anymore." **Anon**

Priorities and continuous improvement

Most governors had a clear vision for their prison and had set out appropriate priorities.

> The governor had set a clear vision for the prison, a realistic strategy and a timetable for delivery, with quantified targets for improvements in outcomes for prisoners.
> **Thameside**

Despite this, our staff survey findings across our inspections has showed that the majority of frontline staff were not always clear about leaders' priorities. The plans to deliver the priorities were often vague and sometimes limited to the implementation of standard processes. Although leaders gathered data to inform their priorities, too often these were not used effectively to devise strategies with measurable outcomes. For example, we often saw violence expressed as a number rather than a more helpful rate per 1,000.

While recovery from COVID-19 and improving safety were common priorities, there had been a loss of focus on other significant areas of work, such as rehabilitation, equality and contact with families.

Partnership working

One key indicator of good leadership is successful collaboration with partners to deliver the prison's aims. The restrictions led to many partner organisations withdrawing their staff from prisons, affecting what they were able to provide for a large part of the reporting year. Although partners continued to deliver some elements of their service remotely, this did not compensate for the loss of direct contact with prisoners.

The biggest impact on outcomes resulted from restrictions to the provision of services such as education, skills and work, and health care. Alongside this disruption, resettlement services were restructured following the unification of community rehabilitation companies into the new Probation Service, which left many prisoners, particularly those on remand, without adequate support before release.

Although governors had no direct control on the delivery of these important services, they were still able to influence outcomes for prisoners. Things were better where they had worked to develop the partnerships and where there was evidence of active dialogue and challenge.

Pace of recovery

Many leaders at all levels expressed frustration at not being able to use their own judgement to move their prison forward at a faster pace. While they understood the need for some consistency across the estate, they were confident that local knowledge and thorough risk assessment could have facilitated a swifter recovery than they were able to achieve within the restrictions of the national framework. The culture they fostered, despite restrictions, clearly determined the pace of recovery. In some prisons, this was slow and not in line with recovery in the local community, creating inconsistencies that prisoners found frustrating and hard to understand.

Outcomes for prisoners were better when leaders struck the right balance between arrangements for their physical health and mental well-being, as well as between fulfilling the prison's rehabilitative purpose and managing a restricted regime. Interestingly, one local prison, rather than a category C or D, managed to strike this balance better than most.

> Leaders had prioritised the prison's recovery, and its pace compared to similar prisons was reasonably swift. They were also proactively driving the move to stage 1 of the national framework for prison regimes and services… Concerted efforts to protect the positive, relaxed culture of the prison were evident… Key work had also been prioritised, which strengthened relationships and contributed to a positive culture. Overall, there was a greater sense of pre-pandemic normality than we have seen elsewhere. **Altcourse**

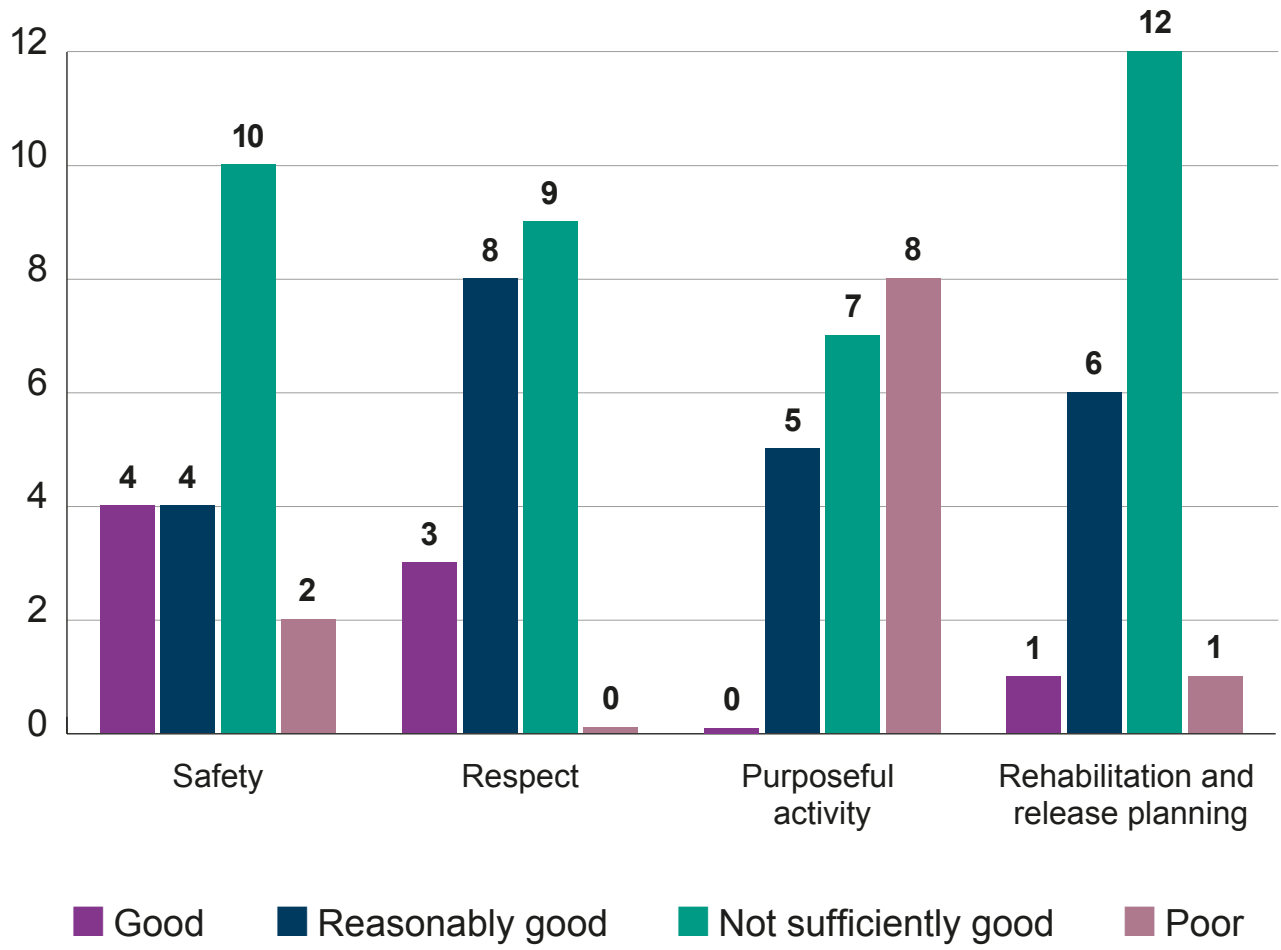
Four

Men in prison

The findings from adult male prison inspections reported in the following section are based on the fifth edition of our **Expectations: Criteria for assessing the treatment of and conditions for men in prisons**, published in July 2017.

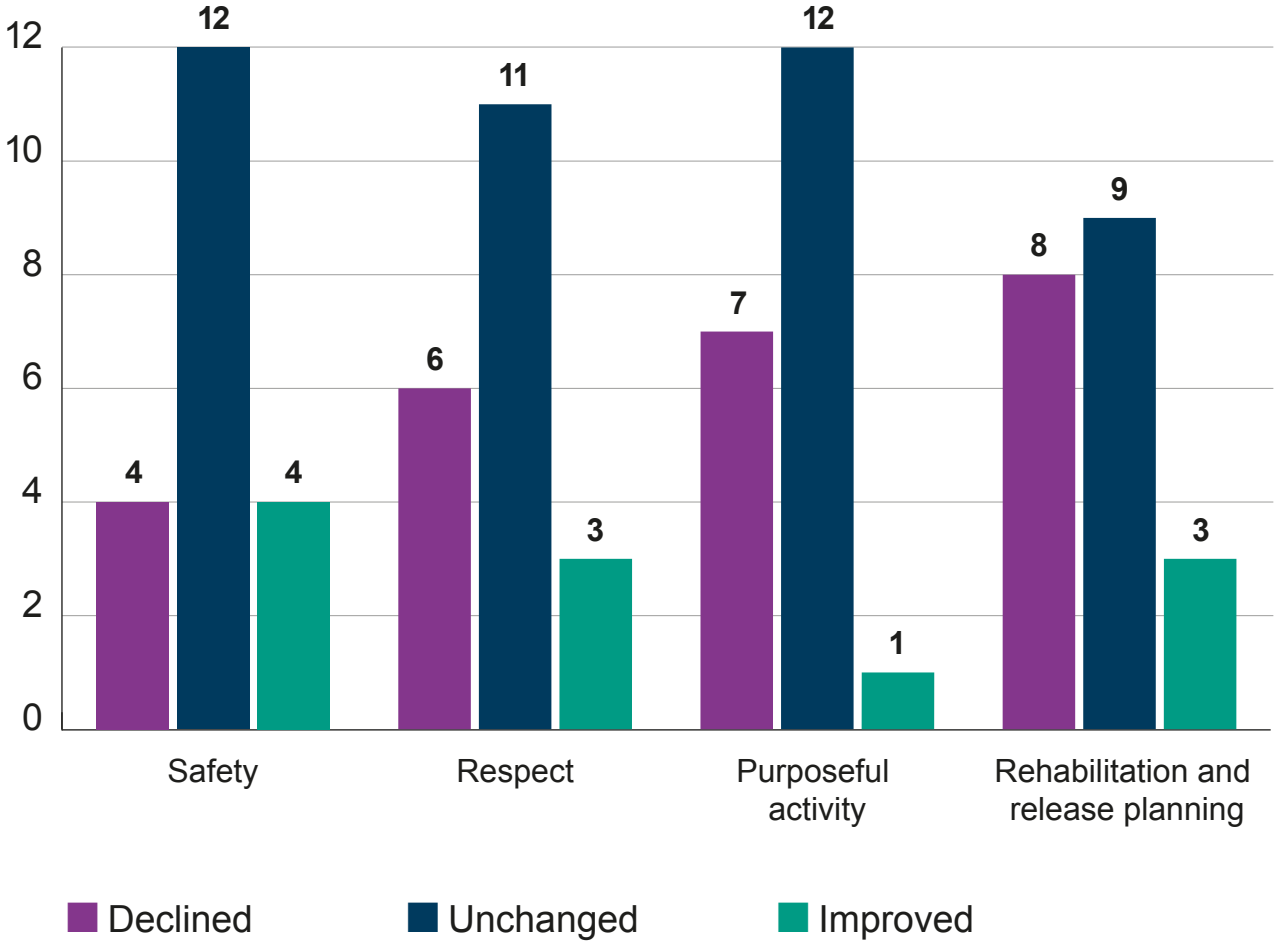
During our full inspections in 2021–22, we visited 19 prisons and young offender institutions holding adult and young adult men and made 20 healthy prison assessments (there were separate assessments for HMP Usk and HMP/YOI Prescoed). See figure 1.

Figure 1: Published outcomes for all prisons and young offender institutions (YOIs) holding adult and young adult men (20)



We have compared the outcomes for the prisons we reported on in 2021–22 with the outcomes we reported the previous time we inspected the same establishments (figure 2). Details for each healthy prison assessment area are also shown in the tables on safety (page 35), respect (page 42), purposeful activity (page 51), and rehabilitation and release planning (page 58).

Figure 2: Outcome changes from previous inspection of prisons and YOIs holding adult and young adult men (20)



Safety

- Safety outcomes were not sufficiently good in half of prisons inspected.
- One in five prisoners told us that they currently felt unsafe, while 43% said they had felt unsafe at some time.
- Drug misuse and lack of purposeful activity contributed to violence and self-harm and had a negative impact on prisoner well-being.
- We continued to identify significant weaknesses in the management of and support for perpetrators of violence, while support for victims was often limited.
- Prisons' analyses of data on key components of safety were often weak and failed to improve outcomes for prisoners.
- While there was positive use of technology, such as body scanners, to support safety and reduce the supply of illicit items, there were inconsistencies in use.
- 74 prisoners took their own lives in the 12 months to March 2022 (down from 78 in the previous 12 months). In the calendar year 2021, 37% of self-inflicted deaths were of prisoners on remand.

Table 1: Safety outcomes in establishments holding adult and young adult men

	Good	Reasonably good	Not sufficiently good	Poor
Local prisons	0	3	4	1
Training prisons	2	1	4	1
Open prisons	2	0	0	0
Young adult prisons	0	0	2	0
Total	**4**	**4**	**10**	**2**

Outcome of previous recommendations

In the adult male prisons reported on in 2021–22, 27% of our previous main/key concern recommendations in the area of safety had been achieved, 24% partially achieved and 48% not achieved.

What happens to prisoners when they arrive?

A prisoner's first experience of arriving in custody can be daunting and concerns for their safety should be a priority. In around a quarter of prisons inspected, the first night safety interviews for new arrivals were not held in private, which potentially reduced the likelihood of prisoners disclosing important information. Most prisons continued to strip search new arrivals routinely with no assessment of their individual risk.

Peer workers provided good support to prisoners in their early days and while most prisons used them, it was disappointing to find that some did not.

> Peer-led support was excellent. On arrival, prisoners were greeted by induction orderlies as well as representatives from other peer-led initiatives. **Oakwood**

Most prisons had a designated reverse cohort unit (RCU) to quarantine all new arrivals. The regime on most of these units was poor with some prisoners locked up for 23 hours a day, often in ill-equipped cells. More positively, prisoners in Haverigg were able to move freely around the RCU and were not confined to their cells, which they appreciated.

Peer workers were often used effectively to help deliver induction programmes, but inadequate supervision and oversight of their role sometimes meant prisoners could be given inaccurate information.

The reception and induction process for prisoners who did not speak English was poor in around a quarter of prisons.

> There was inadequate first night or induction support for prisoners who could not speak English. We saw staff persist with a first night interview even when it became obvious that the prisoner did not understand them. Instead of using professional telephone interpreting services, they eventually asked another new arrival to interpret sensitive information, which was inappropriate. **Belmarsh**

Managing behaviour

As prisons continued their recovery from the restrictions of the pandemic, rates of violence were increasing in half of the prisons that we inspected and in our survey, 20% of respondents said that they felt unsafe at the time of our inspection.

While there had been notable reductions in violence in some prisons, incidents were often serious. In some, such as Woodhill and Chelmsford, violence was increasing despite restricted regimes. More positively, some prisons – including Durham, Haverigg, Manchester, Altcourse and Thameside – had maintained a calm atmosphere and reductions in violence while returning to normal regimes and providing more time out of cell.

Despite some impressive collation of data on safety by some prisons, a lack of detailed analysis undermined the effectiveness of strategies to improve safety outcomes or future planning.

> Data was not analysed well enough to identify key risks or review progress. **Chelmsford**

There were more positive outcomes at Durham, where a robust analysis of safety data had informed the local strategy and led to a notable reduction in recorded violence.

The quality of challenge, support and intervention plans (CSIPs) varied greatly and support for victims of violence or bullying was often weak. Some staff and prisoners lacked understanding of the CSIP process, and for prisoners who were on a plan this meant their progress was not monitored by staff. Swinfen Hall, Haverigg and Brinsford, however, took a more active approach.

> The actions generated both to challenge perpetrators and support victims of violence through the safety intervention meetings and challenge, support and intervention plans (CSIPs) were well managed and effective. Families often took part in CSIP reviews. **Brinsford**

Incentives to motivate good behaviour

Due to the consequences of prolonged COVID-19 restrictions, such as limited time out of cell and lack of meaningful work or education, prisoners had few opportunities and incentives to demonstrate good behaviour. However, there was little evidence that prison leaders had considered alternative ways to motivate prisoners and encourage positive behaviour.

Table 2: Do the incentives or rewards in this prison (e.g. enhanced status) encourage you to behave well?

Local prisons	41%
Category B training prisons	30%
Category C training prisons	44%
Young adult prisons	50%
Open prisons	54%
Overall	**42%**

> Prisoners told us that there was little difference between the incentive regime levels and the scheme did little to motivate them. **Swinfen Hall**

Most prisons placed prisoners on the basic level of the incentives scheme only in exceptional circumstances due to the already limited COVID-19 regimes. But, as we have found previously, these often failed to encourage progression or set targets to address poor behaviour.

There had been a decrease in the use of adjudications in most prisons. When they were used, they were not always effective because too many hearings were delayed or dismissed due to procedural errors. The result was that serious offences sometimes went unpunished and efforts to address poor behaviour were undermined.

> ... 822 [adjudication hearings] were outstanding, some dating back as far as May 2019; and 80 had been referred to the police and were waiting for an outcome. **Swaleside**

Managerial oversight of adjudications in some prisons lacked the necessary rigour to improve outcomes, and the records from hearings that we sampled were not always detailed enough to indicate that they had fully understood the prisoner's experience.

Use of force

The use of force by staff across the adult male prison estate was broadly similar to 2020–21, according to national figures. Although some establishments, such as Deerbolt and Durham, had successfully reduced the use of force, there had been increases at others, including Woodhill and Thameside.

In 13 of the 19 adult male closed prisons that we inspected, we recorded a key concern and recommendation about the use of force.

Poor staff use of body-worn video cameras remained an issue. At several prisons, incidents of use of force were either not recorded at all or cameras were turned on late, limiting the ability of leaders to judge if the use of force was appropriate.

Use of force was sometimes excessive, including unnecessary baton use at Woodhill and Hull, and with swearing and abusive language during restraint seen at Brinsford and Hull. At several prisons, staff were not attempting to de-escalate the situation and reduce the time that force was used against prisoners. Governance of use of force was inconsistent and in some inspected prisons it was inadequate.

Segregation

Most prisoners held in segregation had a too-limited regime, with only 30 minutes a day to shower, use the phone and have time in the fresh air. Although there had been improvements to the physical conditions in some segregation units, many remained poor. Four of the segregation units we inspected continued to have no in-cell electricity, which was unacceptable.

> The segregation unit was bleak, with many cells in poor condition. Only one of the two showers worked, and the exercise yard remained as barren as we observed at the last inspection. None of the cells had access to electricity, other than a light switch and cell call bell. **Deerbolt**

Reintegration planning was not always effective. The governance of segregation varied greatly and there was not always sufficient justification for segregating prisoners or assurance that it was for the shortest time possible. Completion of the necessary documentation was sometimes weak or lacking. In one case, we found an inappropriate overlap between the use of segregation and the prison's inpatient unit.

> ... a prisoner with mental health issues who needed constant supervision was being held in the segregation unit because the appropriate cells in health care were full. **Belmarsh**

But despite poor conditions and a limited regime, relationships between segregation unit staff and prisoners were often good and many prisoners told us that staff treated them well.

> The forensic psychology team was providing invaluable support to the unit. It assisted with the recruitment of segregation staff and provided quarterly one-to-one meetings with them, to help them to manage stress and maintain resilience. **Thameside**

Security

Despite restricted regimes, almost a quarter of prisoners told us that it was easy to obtain illicit drugs. Although more prisons now had access to technology, such as body scanners, to support safety and prevent the entry of illicit items, it was not always used consistently. At some training prisons, such as Deerbolt and Brinsford, all new arrivals continued to be strip searched without any specific intelligence that they had secreted unauthorised items, and at Erlestoke, staff lacked confidence in using body scanners due to insufficient training.

Even though the use of illicit items continued to present a challenge, not all prisons prioritised drug testing to understand the scale of the problem or gave sufficient focus to intelligence-led target searching.

The management of security intelligence had improved in most prisons but, as with other key areas of safety, security data were not always analysed sufficiently. The creation of a regional intelligence hub to support West Midlands prisons was a positive initiative, resulting in an improvement to safety at Swinfen Hall and Brinsford.

> There was a regional hub, where staff worked 24 hours a day, processing information reports from every prison in the region. This hub provided a full assessment of the previous day's information and events by the following morning, allowing leaders and staff to respond to any emerging threats immediately... an in-depth weekly and monthly analysis was provided, which included a breakdown of gang-related issues and their members, enabling leaders to manage these risks effectively. **Brinsford**

Safeguarding

In the year ending December 2021, the rate of recorded self-harm incidents per 1,000 prisoners was down 14% from the year ending December 2019, before the pandemic.

Since resuming full inspections, we have raised key concerns about weak suicide and self-harm prevention measures at more than half of the adult men's establishments inspected. These typically related to a failure to identify risk when prisoners arrived or a broader lack of strategic planning to reduce levels of self-harm. A few prisons, including Rochester and Chelmsford, still did not analyse data to understand the main causes of self-harm in their establishments. Even though data analysis was generally better elsewhere, managers often did not use it to set priorities to reduce self-harm.

In the year to March 2022, there were 74 self-inflicted deaths in adult male prisons, compared with 78 in the previous 12 months, a decrease of 5%. In just under half the prisons we inspected, learning from Prisons and Probation Ombudsman investigations into deaths in custody was not well enough embedded.

We have consistently expressed serious concerns about the impact of the pandemic restrictions on prisoners' well-being – most continued to be locked up for 22 or even 23 hours a day (see page 52).

> Prisoners on ACCTs [self-harm monitoring] to whom we spoke said... that the prolonged periods locked up exacerbated their low mood. **Wandsworth**

At about a third of the prisons we inspected, there were no longer enough Listeners (see Glossary). Even when they were available, restrictions and staff shortages meant that prisoners were not routinely unlocked to see them. In our survey, only 36% of prisoners told us that it was easy to speak to a Listener. Training of new volunteers was slowly restarting.

At Manchester, Belmarsh and Chelmsford, staff struggled to implement the latest version of HMPPS casework designed to coordinate assessment, care in custody and teamwork (ACCT) support for prisoners at risk of suicide or self-harm. They did not always feel sufficiently confident and had not had enough training. In our survey, only 55% of prisoners told us that they felt cared for while receiving ACCT support.

Although more creative forms of support to help prisoners manage their low mood were uncommon, we did find some excellent examples. These included a nature trail at Haverigg, a well-being check on prisoners after their legal visits at Oakwood and animal therapy at Altcourse.

Procedures to ensure that the most vulnerable prisoners at risk of harm, abuse and neglect were systematically identified and protected were usually no more than adequate. Links to local adult safeguarding boards had often lapsed and prison staff typically needed training in the area of adult safeguarding.

Respect

- The very limited time that prisoners had out of their cells continued to hamper their relationships with staff, and key working had been slow to restart.
- Overcrowding continued in most prisons and, for many, living conditions needed significant improvement, but additional cleaning of communal areas continued to be a positive outcome of infection-control measures.
- Consultation with prisoners was still limited, with some positive exceptions. Prisoners did not always have confidence in applications and complaints systems.
- Work to support prisoners with protected characteristics was far too limited; they had more negative perceptions in some key areas, and prisons did not do enough to identify and address disproportionate outcomes for them.
- Although access to corporate worship had remained restricted, chaplaincies in most prisons were active in providing individual support and guidance.
- Health services continued to respond to ongoing needs and implement recovery plans amid intermittent In the year ending December 2021, the rate of recorded self-harm incidents per 1,000 prisoners was down 14% from the year ending December 2019, before the pandemic.
- Health services continued to respond to ongoing needs and implement recovery plans amid intermittent COVID-19 outbreaks, but prisoner access to care was sometimes affected by shortages of both health and prison staff.
- Mental health services had restarted and were supporting prisoners whose well-being had suffered during lock-up and isolation.

Table 3: Respect outcomes in establishments holding adult and young adult men

	Good	Reasonably good	Not sufficiently good	Poor
Local prisons	0	4	4	0
Training prisons	2	2	4	0
Open prisons	1	1	0	0
Young adult prisons	0	1	1	0
Total	**3**	**8**	**9**	**0**

Outcome of previous recommendations

In the adult male prisons reported on in 2021–22, 26% of our previous main/key concern recommendations in the area of respect had been achieved, 26% partially achieved and 48% not achieved.

Staff-prisoner relationships

In our prisoner survey, different groups varied notably in their views of staff treatment and care. For example, those with disabilities were far more negative while older prisoners were far more positive.

The lack of time out of cell as a result of the COVID-19 restricted regimes and shortage of officers on duty continued to hinder the opportunities for staff and prisoners to build positive relationships. Staff were also so often focused on running the restricted regime to time that they were unable to give prisoners individual attention, which was perceived as a lack of care or compassion. While we observed positive and supportive interactions in some establishments, we too often found staff congregating in offices away from those in their care and a lack of challenge of antisocial behaviour.

> A staff habit on Silbury B highlighted this issue: the one-way glass in the staff office, coupled with the practice of leaving the office light off, further impeded any meaningful contact and we routinely witnessed staff on this unit ignoring prisoners' requests for help. **Erlestoke**

The key worker scheme (under which staff have regular contact with named prisoners) was suspended at the start of the pandemic and had been slow to be reintroduced. We found little evidence of meaningful contact, other than brief welfare checks, which limited the opportunity to make ongoing assessments of prisoners' well-being beyond very basic observations.

Day-to-day life

Even though the numbers held in some prisons had been reduced, we still found far too many prisoners sharing a small cell designed for one. Wandsworth was the most chronically overcrowded of all prisons with around 1,000 prisoners living in cramped conditions. Prisoners continued to be locked up for almost the whole day, often in poorly ventilated cells, which led to intolerable conditions for many in hot weather.

Enhanced COVID-19 cleaning continued in communal areas at most prisons. However, many cells were dirty and in a poor state of repair, with toilets lacking a seat and lid. Vermin was a major problem at some prisons.

> Despite some work to control the issue, litter and waste food were often thrown from cell windows, contributing to the problem with vermin, including many rats, mice and pigeons. The vermin were not limited to the external areas and we found evidence of rat faeces in living accommodation and offices intended for key workers and offender managers to interview prisoners. **Wandsworth**

Meals are always important in a prisoner's day, and even more so during the restrictions they faced this year. In our survey, only 41% of adult male prisoners thought the food was good and only 39% said they got enough to eat each day. We saw meals being served far too early; in one prison the evening meal was served at 2.30pm. Most self-catering facilities had been suspended and some of those that remained were very limited and in a very poor state of cleanliness.

Newly arrived prisoners often had to wait far too long to receive their first order from the prison shop, which left them vulnerable to getting into debt and potential bullying. Although prisoners could shop from catalogues, this had become a problem as most providers had moved their catalogues online, which prisoners could not access directly, and orders often took too long to be distributed.

Prisoner consultation forums had continued in most prisons, but many met infrequently and lacked structure or a focus on outcomes achieved. At Chelmsford, the council had met without any prisoners present, which defeated its purpose.

Some prisoners were negative about the process for applying for day-to-day requests. Although many prisons had replaced paper application forms with electronic kiosks on the wings, prisoners had very little time out of cell to use them, and delays in responses were common.

Table 4: Are applications usually dealt with within seven days?

Local prisons	39%
Category B training prisons	28%
Category C training prisons	37%
Young adult prisons	25%
Open prisons	62%
Overall	**38%**

Prisoners continued to lack confidence in the way that complaints were handled, and in our survey only 31% of those who had made a complaint said it had been dealt with fairly. Analysis of data about complaints and quality assurance of replies were limited. For example, in three prisons inspected, leaders were unable to identify trends or address the most persistent problems that prisoners faced.

Equality and diversity

Equality and diversity work continued to be an area of weakness, and we raised key concerns and recommendations about this in around half of our reports.

While many prisons had re-established regular equality meetings and had paid some attention to the organisation of equality work and responsibilities, this was often undermined when teams were inadequately resourced or equality staff were regularly cross-deployed. Haverigg was one of the few prisons with a well-founded approach, underpinned by a realistic action plan with regular and well-attended meetings.

Equality monitoring data were a concern in virtually all our inspections. National data were often out of date and local data were not always gathered. Even when available, data were not analysed fully every time or used effectively to address disproportionate treatment.

Investigations into discrimination complaints were not always thorough, although we did identify some good responses. Quality assurance was generally absent or weak, but at Chelmsford, Wandsworth and Woodhill external organisations provided independent scrutiny.

There were not enough prisoner equality representatives in many prisons, and those in place lacked a job description for the role and rarely had any training. The ongoing COVID-19 restrictions often limited their movement around the prison, which reduced their effectiveness. However, at Durham, Haverigg and Oakwood they felt valued and had been given support to fulfil their roles, and those at Thameside had received good training and oversight.

Consultation with prisoners on equality matters was often far too limited, with few meetings taking place.

Prisons needed to do much more to engage with community groups to promote diversity and inclusion, although some showed positive approaches.

> Recent developments to engage with groups such as the Zahid Mubarek Trust, Inside Belief and the Irish Council for Prisoners Overseas were promising steps forward in the prison's efforts to promote diversity and inclusion. **Thameside**

In our survey, ethnic minority prisoners had more negative perceptions than white prisoners in some key aspects of treatment and conditions. For example, far fewer said that staff treated them with respect (60% compared with 74%) and that they felt treated as an individual (42% compared with 53%). They also consistently reported less confidence in the handling of complaints (21% compared with 35%) and applications (43% against 57%).

Prisoners from the Gypsy, Roma and Traveller communities also reported poorer outcomes in some key areas, but at Rochester awareness training for staff had been arranged to promote a better understanding of the issues these prisoners faced.

We inspected several establishments with high numbers of foreign national prisoners, many of whom were uncertain of their future after release. In Belmarsh, Wandsworth and Wormwood Scrubs, Home Office staff had moved off site during the pandemic and had not fully returned when we inspected. This meant there were no face-to-face meetings with prisoners, who were lucky if they got a phone call in response to their concerns. At Wandsworth, we came across cases where prisoners were served an authority to detain notification (IS91) on the day of release, which meant they were kept in custody beyond the end of their sentence. Foreign nationals also continued to have limited access to legal advice about their immigration status. Some prisons still failed to provide any information translated into foreign languages and made little use of professional interpreting services, which prevented some foreign prisoners from understanding important information.

In our survey, prisoners who said they had a disability had worse perceptions about some of their treatment and conditions than those without. Some prisons did not have enough adapted cells or accessible facilities.

> We saw examples of prisoners with very reduced mobility (some of whom had a personal emergency evacuation plan, PEEP) located on upper floors. One prisoner on the first floor had to have his meals brought up to him from the servery. **Durham**

Many prisons used prisoner ‘Buddies’ to provide support for prisoners with disabilities, but too many had insufficient training, supervision or oversight from staff. In more than half of our inspections, individual evacuation plans were of insufficient quality and staff awareness of them was often poor.

In our survey, prisoners aged over 50 were much more positive about many aspects of prison life. In contrast, young adult prisoners were far more negative about staff and more felt victimised. There was little consultation with this group and prisons did not always take action when monitoring identified disproportionate outcomes. We found little specific support for these prisoners, although some prisons offered maturity screening and follow-on work to address psychosocial development and Thameside had a range of initiatives, including access to the Duke of Edinburgh’s Award scheme.

In our surveys, more LGBT+ prisoners than those who were not said they had been victimised by other prisoners. Although there had been forums at a few prisons, active work to support prisoners who were gay, bisexual or another sexual orientation and promote tolerance was rare. Hull had organised a month of engagement and celebration events, and a survey of prisoners had led to access to the LGBT+ community helpline.

Transgender prisoners experienced varying levels of care, but Hull and Thameside had shown good planning with external agencies for their arrival.

Chaplaincies had continued to provide spiritual and pastoral care throughout the COVID-19 restrictions, and in our survey, 65% of prisoners said their religious beliefs were respected. Good practice included chaplains meeting all new arrivals, and at Durham a chaplain saw all those due to be released. Corporate worship had been generally slow to restart and social distancing measures meant that it was not available every week for those who wanted to attend.

Health, well-being and social care

Health services demonstrated continued resilience, responding to ongoing needs and implementing recovery plans amid intermittent COVID-19 outbreaks, increased testing and mass vaccinations. The level of staffing determined the capacity of health providers to deliver safe and effective care, including the availability of prison officers to facilitate prisoner access to health services.

Effective action to reduce pandemic risks to prisoners

Prisons took effective action in partnership with NHS England and Improvement and local prison health boards in Wales, public health bodies and HMPPS to manage COVID-19 in prisons and implement the mass vaccination of prisoners, which began to be rolled out from March 2021. Despite concerted promotional efforts by health services, uptake for vaccinations in most adult male prisons was lower than in women's prisons and the community. New arrivals and those with the infection were held apart and tested, and prisons continued to offer shielding for the most vulnerable after changes to national guidelines in the community from April 2021.

Between April 2021 and 31 March 2022, 45 prisoners had died within 60 days of having tested positive for the virus or where there was a clinical assessment that COVID-19 was a contributory factor in their death. Of these, 34 were suspected or confirmed to be caused by COVID-19. The upsurge in the more infectious Omicron variant saw most prisons in outbreak status in December 2021, with 4,370 confirmed cases of COVID-19 in prisons in England and Wales and eight deaths that month.

Health services at most sites continued to adapt their facilities to maintain provision, helped by the roll-out of in-cell telephones allowing health providers to make calls directly to patients, mirroring some community services.

The health providers in half the prisons we inspected had maintained good oversight and risk management. In others, we saw weaknesses in governance, often due to a combination of scaled-down strategic oversight and local staff shortages. As managers stepped into direct patient care roles, leadership and oversight of risks were compromised.

> Staffing shortages were having a detrimental impact on the provision of health care in all areas. There were 264 prisoners on the waiting list for the GP, with the longest wait at eight weeks, and there was no evidence of risk management in the clinical records. **Durham**

Reliance on agency staff to cover vacancies was considerable, with as many as 10 agency mental health nurses and an agency team leader at Chelmsford; this impinged on therapeutic relationships and continuity of care.

Restrictions on time out of cell had affected prisoner access to health services as they could not post applications for appointments into boxes; the electronic applications systems in place were an advantage, despite some ongoing IT failures. The restrictions limited access to certain health professionals, which created lengthy waiting lists with some prisoners leaving prison before they were assessed or treated. Most allied health professionals, such as opticians, podiatrists and physiotherapists, had restarted their clinics in the last year.

> The primary care team was passionate, highly motivated and had continued face-to-face nurse triage during the pandemic. There was good access to a range of age-appropriate primary care services... Allied health professionals had restarted visits to the prison and were progressing through their waiting lists, with an average wait of around five weeks. **Brinsford**

However, we also saw many prisoners without glasses or with blurred vision waiting many months to see an optician, and a few prisons had no prioritisation or risk management of waiting lists.

> ... there were 150 patients on the GP waiting list with some waiting more than five weeks. There had been no clinical prioritisation of these patients, 32 of whom were awaiting an ECG. Patients who required annual blood tests had not been put on the phlebotomy waiting list. **Hull**

Where prisons were planning alternative and innovative options, these improved prisoner access to some health services.

> A new visiting orthopaedic clinic had been established recently. The on-site diagnostic X-ray facilities were now fully functioning, and the interim head of health care was in the process of establishing a fracture clinic, as well as a small dialysis unit. **Thameside**

Care for patients with long-term conditions had improved, with a clear focus on identifying vulnerable prisoners, and most had been reviewed within national health guidelines. Although there were delays due to a lack of access to health care, and some sites had to improve the quality of individual care plans, we saw good management overall.

There had been an increase in outside hospital appointments, but a third of prisons we inspected regularly cancelled them due to the lack of officer escorts.

> The number of prison escorts had been reduced to four days a week…This meant there were up to 16 fewer hospital appointments per month. Escorts could also be cancelled due to prison staff shortages. **Rochester**

In our survey, about half of prisoners said they had a mental health problem. Although the easing of COVID-19 restrictions had been some help to social isolation, the lengthy time that prisoners continued to spend locked in their cell was challenging for those with mental health conditions. Most mental health services were progressing with recovery plans to reinstate clinics and psychological interventions, and most were now delivering face-to-face appointments. In our survey, 31% of prisoners told us that it was easy to see a mental health worker.

The needs of neurodivergent prisoners

Neurodiversity in the criminal justice system, the thematic review we produced this year with HM Inspectorate of Probation and HM Inspectorate of Constabulary and Fire & Rescue Services, examined how the criminal justice system was meeting the needs of neurodivergent people (in the review this referred to those with a condition that fell under the broader category of neurodevelopmental disorders, such as learning difficulties and disabilities, common conditions such as attention deficit hyperactivity disorder (ADHD) and autism spectrum conditions, and cognitive impairments due to acquired brain injury) and found patchy, inconsistent and uncoordinated provision. Too little was being done to understand and meet the needs of individuals.

The review revealed a wide range of adaptations and adjustments being made in various places in the criminal justice system for individuals whose needs had been identified. They included many simple and low-cost solutions that could make a huge difference to many people if they were provided universally.

We concluded that, with more effective assessment of need, adaptation of services and better training of staff, it is possible to support those with neurodivergent conditions and help break the cycle affecting too many – crime, arrest, court, prison, probation and reoffending.

The report, commissioned by the Secretary of State, made six recommendations that will, we hope, set out a course for ministers on what needs to be done, and transform the experiences and outcomes for those in the criminal justice system with neurodivergent needs.

This year we saw more face-to-face psychosocial interventions for prisoners with substance misuse needs, as well as in-cell workbooks. Group meetings remained restricted and limited the ability to deliver interventions. This was reflected in our survey where only 30% of prisoners said it was easy to see a substance misuse worker. Clinical prescribers continued to provide a safe, evidence-based service to those with addictions.

Almost all prisons had maintained a consistent supply of medicines with good oversight and governance. Any problems occurred where there was a lack of pharmacy presence. Many prisons had implemented contingencies to prioritise the supply of medicines, and isolated prisoners could access their medicines during COVID-19 restrictions. But once the initial restrictions had eased, we saw the continuation of some unsafe practices.

> A few IC24 staff used lockable trolleys to transfer medicines to the wings, but several staff were using open baskets, which was unsafe. We observed IC24 and Forward Trust staff administering medication, including controlled drugs, without a prescription chart. **Swaleside**

Where there was a consistent pharmacist presence, we saw excellent oversight of prescribing and medicines, and identified five examples of positive practice, including the use of a pharmacist on the first night centre in Wormwood Scrubs and comprehensive reviews of sedating medicines at Erlestoke.

Dental services were slowly improving with the reintroduction of many clinics. Most prisons had dental facilities that allowed good management of infection prevention and control. Dental staff prioritised patients in pain and with infection, and managed the risks associated with longer waiting times. However, some prisons were still not undertaking aerosol-generating procedures (see Glossary) due to prison restrictions, which resulted in protracted waiting times – exceeding one-and-a-half years for some at Erlestoke.

Purposeful activity

- Pandemic restrictions continued to reduce severely prisoners' time unlocked and they routinely spent up to 23 hours a day in small, overcrowded cells, with a detrimental impact on their mental well-being. Even when restrictions began to lift, the pace of recovery was far too slow and many prisoners were still locked up for almost 22 hours a day.
- Most libraries had remained closed and access to gyms was also heavily curtailed, especially earlier in the year; with other out-of-cell activities largely suspended, the opportunity for social interaction was limited.
- The approach to reopening classrooms was overly cautious, and the quality of in-cell learning had generally not improved. The lack of face-to-face teaching had the most negative impact on prisoners with low levels of literacy and additional learning needs.
- A lack of education, training and work continued to disadvantage prisoners and there was little opportunity to gain qualifications. Work to monitor the quality of teaching and learning had dwindled to almost nothing in most prisons.
- The quality of prison education, which was already poor in delivery and outcomes, was made worse by the pandemic restrictions, which also affected access. Approximately a third of the progress monitoring visits by Ofsted, which began in May 2021, found insufficient progress in reinstating a full education, skills and work curriculum. After Ofsted resumed full inspections in October 2021, no provision they inspected with us was judged good or outstanding.
- Our joint research project with Ofsted found that prisons did not prioritise the improvement of prisoners' reading ability and that most teachers did not know how to teach reading.

Table 5: Purposeful activity outcomes in establishments holding adult and young adult men

	Good	Reasonably good	Not sufficiently good	Poor
Local prisons	0	1	3	4
Training prisons	0	2	4	2
Open prisons	0	2	0	0
Young adult prisons	0	0	0	2
Total	**0**	**5**	**7**	**8**

Outcome of previous recommendations

In the adult male prisons reported on in 2021–22, 8% of our previous main/key concern recommendations in the area of purposeful activity had been achieved, 8% partially achieved and 85% not achieved.

Locked up most of the time

The pandemic and staff shortages continued to reduce severely the time that prisoners in closed prisons spent unlocked. We found most prisoners locked up for around 23 hours a day at Deerbolt, Chelmsford, Hull and Wandsworth.

Many prisoners told us that spending so much time confined in a small and often overcrowded cell, which could be stiflingly hot in the summer, was detrimental to their mental well-being. More than 16 months after the pandemic began, one prisoner commented:

> ‘My mental health is at a breaking point. I get 30 minutes a week in the gym. I have been very lonely throughout the COVID-19 pandemic and was really frightened and it has left me unstable’. **Chelmsford**

New arrivals usually spent even less time out of their cell while they were in quarantine. At Thameside, new prisoners were unlocked for little more than 30 minutes a day, and those in isolation at Hull due to COVID-19 had no access to the open air for 10 days and could only shower after a week.

More than half of all prisoners were in their cells for at least 22 hours on weekdays.

Table 6: Do you usually spend less than two hours out of your cell on a typical weekday (including time spent at education, work, etc.)?

Local prisons	66%
Category B training prisons	44%
Category C training prisons	50%
Young adult prisons	63%
Open prisons	4%
Overall	**53%**

Time out of cell at weekends was even worse, with an average of 69% locked up for more than 22 hours on Saturdays and Sundays.

For prisoners in open conditions and in some of the temporary accommodation that had been installed in closed prisons, time unlocked was better, with prisoners at Haverigg getting 13 hours a day out of their room. However, only 8% of prisoners overall in our survey said they were out for more than 10 hours on a weekday and just 5% of prisoners spent more than 10 hours unlocked at weekends.

We had concerns about the impact of this extended period spent without regular social interaction on the well-being of young adults. At Deerbolt and Brinsford, we found many, mostly young, prisoners bored, spending the day sleeping in their cells or watching television.

As COVID-19 restrictions eased, prisons required HMPPS approval of recovery plans to move from the most restricted regime (stage 4) to the least (stage 1). Prisoners, aware of the relaxing of restrictions in the community, were frustrated by the slow pace of change in prisons.

> Prisoners were unlocked for... activities with others from their landing, in groups of up to nine at a time. Mixing across landings for showers, telephone calls, time outside and gym was not allowed. It was not clear why, as time progressed, group sizes had not been increased gradually, to improve time out of cell for all prisoners. **Deerbolt**

There were frequent regime changes as prisons moved through the stages of recovery, but these were not always communicated to prisoners. A shortage of staff at Rochester, Woodhill and Wandsworth further limited the ability to deliver the regime.

Access to the open air also varied. Planned exercise periods outdoors were often too short and prisoners said that even these were not fully delivered.

> Access to the open air was inadequate for many and woeful on Trinity, which was at best 45 minutes to an hour every three days. Prisoners frequently complained of long periods, sometimes amounting to weeks, without any outside exercise. **Wandsworth**

Most exercise yards had static exercise equipment and benches for prisoners, but some were stark, bare and even cage-like. However, at Hull some of the smaller yards had been developed to attempt to provide a therapeutic and calming environment.

Libraries and gyms slowly reopen

Most prison libraries had remained closed or inaccessible to prisoners for much of the year, with library staff remaining off site. Some prisons ran a mobile library service, but this was often not sufficient; for example, library staff delivered just 20 books a day to prisoners in Wandsworth, which held some 1,300 prisoners. There were exceptions.

> The library had been responsive to the needs of prisoners and had worked hard to support them through providing reading and viewing material during their excessive periods spent in cell. **Erlestoke**

Some prisons had reinstated activities to promote reading, with more than 250 prisoners at Manchester taking part in Reading Ahead's 'six-books challenge'.

Prisoner access to gyms also remained severely curtailed, especially earlier in the year. Most prisons made good use of external gym areas to provide at least some activity. With the lifting of community restrictions from June 2021, indoor gyms began to be reinstated. We found some impressive initiatives.

> The PE instructors delivered a range of sports activities to encourage prisoners to remain active and to suit a wide spectrum of ages. They designed competitions imaginatively to encourage inclusive physical activity ranging from low impact games such as boules through to circuit training. **Haverigg**

At some prisons, such as Chelmsford, physical activity had been hampered by frequent redeployment of PE staff to cover staff shortfalls elsewhere. At most prisons, take-up of PE was poor with few gym sessions running at anywhere near even restricted capacity. In our surveys, only 20% of prisoners said they went to the gym at least twice a week. Other out-of-cell recreational activities, such as pool and table tennis, remained largely suspended.

Classrooms and workshops remain empty

The return to education and training was sluggish in many prisons. Wormwood Scrubs was slow to resume any classroom work when restrictions were lifted, and by the time we inspected Wandsworth in September 2021, prisoners had not been to the education block since it closed in March 2020. Even as late as November 2021 when we inspected Durham, the return to face-to-face learning was slow, partly due to staff shortages.

When classes and workshops reopened, they remained near empty. The shortage of prison staff to take prisoners to them was a key obstacle in prisons such as Manchester, Swaleside, Erlestoke and Rochester. In Erlestoke, we found only five prisoners in spacious workshops and four in the whole of the education building.

At Swinfen Hall in July, classrooms were not filled because of restrictions on the mixing of prisoners from different 'bubbles', even though desks were set apart to prevent infection; as a result, classrooms held only three or four prisoners or lay empty while others were locked up on wings. At Thameside, we noted that staff shortages 'contributed to prisoners losing their motivation to attend education, skills or work'.

The quality of in-cell learning methods had generally not improved throughout the pandemic. They did not meet the needs of those with a learning difficulty or for whom English was a second language. In-cell learning was also no substitute for the practical hands-on work expected in vocational training. While Swaleside provided a broad in-cell curriculum, engaging more prisoners with education than before the pandemic, in too many places requests for packs were either ignored or took too long to fulfil, and take-up of in-cell packs was often relatively low.

> Leaders did not plan a coherent in-cell learning curriculum that developed learners' knowledge over time… Leaders and managers did not consider learners' starting points when issuing them with in-cell work packs. Learners simply selected the packs they wished to complete... packs included activities that were not age appropriate – they used childish illustrations or referred to children in school. **Manchester**

Teachers rarely used the in-cell telephones available to speak with prisoners and support their learning. A few prisoners at Belmarsh had access to laptop computers to support learning in their cells. For Open University students, the 'virtual campus' IT facility (see Glossary) was in use at Haverigg, but not at Hull or Woodhill.

Where classroom teaching had resumed, there was not always a creative approach to designing and delivering learning that blended in-cell and face-to-face approaches. Thameside stopped issuing in-cell learning packs when classes resumed and, in consequence, the number engaged in education dropped sharply. But at Haverigg, prisoners were taught in classrooms in groups of five, with in-cell packs supplementing the face-to-face sessions with tutors.

Teacher feedback to prisoners was patchy. At Rochester, following the second period of national restrictions, education staff were only able to visit prisoners on the wings at lunchtime to chat through a locked door or during brief unlock periods. At Hull, teachers gave regular feedback, but this was much less the case at Wandsworth and Swaleside.

Throughout this period, most new arrivals did not have access to induction or effective information, advice and guidance. At some prisons, staff relied on new arrivals filling in forms or packs in their cells for assessment, which were a struggle for many with poor English or literacy. Even as late as October, arrivals at Rochester completed induction and assessment activities unsupported in their cell, including 'self-declaring' whether they had any additional learning needs.

Prisoners with specific learning needs risked losing out the most in the scaling down of education, skills and work provision. At Brinsford, there had been no priority in giving face-to-face work to those with additional support needs or who had struggled to learn in their cell. Swinfen Hall was an exception: when restrictions eased, prisoners who found independent learning difficult were prioritised to attend face-to-face learning and receive learning support. At Hull, support was available, but leaders relied too heavily on prisoners to identify their own learning support needs.

Most prisoners had little opportunity to gain qualifications, with some exceptions at Manchester, Erlestoke and Swaleside.

Reading in prisons

Our reading in prison research project conducted jointly with Ofsted – **Prison education: a review of reading education in prisons** – found that prisons did not prioritise the improvement of prisoners' reading ability. With literacy levels worse among prisoners than in the general population, it was shocking that the opportunity for those in prison to learn to read or improve their reading skills was so meagre.

In five of the six prisons visited, reading was not integral to the curriculum, which was not designed to improve the reading ability of those who needed it most. Few teaching staff had the knowledge and training to teach reading.

Educational assessments were inappropriate for identifying prisoners who struggled with reading and teachers did not know what they had learned in previous prisons. Learners' progress in reading was rarely monitored. Resources to help prisoners practise their reading were not easily available, and libraries were largely an untapped resource.

The teaching of the early stages of reading was mainly left to voluntary organisations, such as the Shannon Trust, but they were not given enough time with prisoners or allowed the appropriate space to meet them.

Unhelpfully, lessons were designed to fit the prison's regime, not the needs of learners. As one tutor told us: 'You can't teach phonics through a cell door'.

While some prisoners were employed, this was generally part time and only in essential tasks around the establishment. A few prisons made sensible use of prisoners' skills. Haverigg deployed them on projects in the grounds and a new workshop to use reclaimed steel. Oakwood introduced an affordable clothing line that was prisoner led. Hull used well-qualified prisoners as peer mentors in education and work.

Many prisoners told us they were bored. Even the resources available were often not well used – at Altcourse, a third of the work spaces were not filled, even though a third of prisoners were unemployed. Most prisons had paused vocational training, although a newly opened restaurant at Wormwood Scrubs gave a few prisoners the chance to gain skills and a qualification in hospitality and catering.

Overall, the recovery towards reinstating full education, skills and work was very slow.

Rehabilitation and release planning

- Support to help prisoners build and maintain relationships with their families was still too limited, but their isolation was partially offset by video-calling facilities, some return to social visits and the provision of in-cell telephones at about half the inspected prisons.
- The implementation of the offender management in custody (OMiC) model (see Glossary) was severely hindered by staff shortages and restricted time out of cell.
- Work to protect the public was of variable quality, with backlogs in monitoring the phone calls of prisoners identified as a public protection risk and variable attendance at risk management meetings.
- Eligible prisoners waited too long for transfer to open conditions, causing frustration and loss of motivation.
- There were greatly reduced prisoner numbers and high waiting lists for the offending behaviour programmes provided.
- The use of release on temporary licence (ROTL) for rehabilitation was low, but some open establishments were making good progress.
- The number of unsentenced prisoners had increased substantially and they were not given adequate resettlement support.
- Many prisoners were released homeless and those who needed support had been negatively affected by new contracts with accommodation support agencies.

Table 7: Rehabilitation and release planning outcomes in establishments holding adult and young adult males

	Good	Reasonably good	Not sufficiently good	Poor
Local prisons	0	1	7	0
Training prisons	0	2	5	1
Open prisons	1	1	0	0
Young adult prisons	0	2	0	0
Total	**1**	**6**	**12**	**1**

Outcome of previous recommendations

In the adult male prisons reported on in 2021–22, 33% of our previous main/key concern recommendations in the area of rehabilitation and release planning had been achieved, 17% partially achieved and 50% not achieved.

Family links still disrupted

Support to help prisoners build and maintain relationships with their families continued to be limited by COVID-19 restrictions. Where there was still some provision, it was usually delivered remotely and many pre-pandemic opportunities to build ties between prisoners and their families – such as family days, face-to-face relationship courses and homework clubs – remained suspended. However, we also saw some innovative work.

> Positive initiatives included prisoners having a 'selfie' picture taken against the artwork in the visits hall and printed on to postcards to send home, Father's Day crafting card packs sent to children and letter-writing home packs for prisoners. **Wandsworth**

Social visits operated intermittently over the year. Most prisons were ready to reintroduce visits safely and swiftly, but take-up was low and ongoing restrictions discouraged prisoners and their families from taking the opportunity to attend.

> ... many families lived far away, and the one-hour duration of visits meant they were not worthwhile or realistic for many. Prisoners also told us the restrictions and limited nature of the visits – such as the lack of refreshments and children's play facilities, expectations that young children would remain seated throughout and the ban of any physical contact – had dissuaded their families from booking. **Erlestoke**

All prisons had secure video-calling facilities and, while take-up was varied, they were a valued resource.

In about half the prisons we inspected, prisoners had in-cell telephones, which were vital in enabling them to maintain family contact during long periods locked up. For those who were not so fortunate, the isolation could be a source of great frustration: many prisoners did not have enough time out of their cell to use the limited number of communal phones on wing landings and they could not always use them at times when their families were available.

Problems with implementing the new offender management model

In our survey, only 56% of prisoners reported that they were less likely to offend in the future as a result of their experiences in the prison.

Table 8: Do you think your experiences in this prison have made you less likely to offend in the future?

Local prisons	56%
Category B training prisons	42%
Category C training prisons	59%
Young adult prisons	52%
Open prisons	69%
Overall	**56%**

The offender management in custody model (OMiC) is central to HMPPS's approach towards supporting prisoners' rehabilitation and resettlement into the community. But its implementation was severely hindered by staff shortages and restricted time out of cell, which meant that many prisoners did not have the support envisaged by the model to help them progress through their sentence. Contact with prison offender managers (POMs) was too infrequent and did not drive sentence progression.

> Caseloads were too high, which affected prison and probation offender managers' ability to complete assessments and have meaningful contact with prisoners... Prison and probation offender managers were carrying caseloads of 100 prisoners each. **Oakwood**

But there were positive exceptions, which demonstrated that quality and consistent contact with prisoners could be delivered in some parts of the prison estate.

> [POM] contact was face-to-face... including one-to-one interventions to support sentence plan objectives or to reinforce earlier learning from formal programmes... Contacts were enhanced by the OMU [offender management unit] drop-in centre... Prisoners could call into the centre in the morning... to arrange a meeting for the same afternoon with a duty POM. **Haverigg**

Another encouraging element of OMiC at several prisons was the introduction of a senior probation officer (SPO) as the head of offender management delivery. This had a positive impact on the quality of this work, such as improved assurance and expertise on risk management matters at Woodhill, and well-led and properly trained teams who received regular supervision at Belmarsh and Brinsford. Establishments without an SPO had a notable gap in knowledgeable leadership, with deficiencies in the management of risk and weak oversight of public protection work.

The backlog of assessments of a prisoner's risks and needs through the offender assessment system (OASys) continued to reduce across most prisons, but too often they were completed by telephone or a self-reported questionnaire, undermining the quality of assessment gained through in-person, face-to-face contact. Reviews often did not take place when required.

> ... 87% of prisoners had not had a review in the last 12 months... The prison did not always review the assessment when there had been a significant change in risk circumstances – for example, when they had changed prison or there had been a serious breach of non-contact arrangements while under telephone and letter monitoring. **Swaleside**

Inconsistent work to protect the public

Backlogs in monitoring the phone calls of prisoners identified as a public protection risk remained a concern and we saw delays of many weeks at Manchester, Chelmsford and Woodhill. At Belmarsh, a high-security establishment, prison leaders were surprised when we found that calls by several prisoners had not been monitored for many weeks, and that some individuals had not been monitored at all. At several prisons, calls in foreign languages were not translated routinely.

Regular interdepartmental risk management meetings are important to ensure prompt information-sharing and pre-release planning for high-risk prisoners and those who require multi-agency public protection arrangements (MAPPA). Attendance at these meetings by key people from outside the OMU, such as security and residential staff, varied significantly. However, we identified some positive practices at Deerbolt, Thameside and Durham, where the community offender manager (COM) dialled into the risk management meetings, and we saw examples of effective information-sharing between the prison and the community before release.

> The interdepartmental risk management meeting had been overhauled and now considered all forthcoming high-risk releases in detail... Our case analysis sample consistently showed active engagement between prison and community offender management staff to identify MAPPA levels and describe risks, and plans to manage any identified risks. **Wormwood Scrubs**

Delays in progression opportunities

Prisoners granted category D status continued to wait too long for transfer to open conditions. Reasons for this included difficulty with securing transport, a lack of specialist and suitable accommodation elsewhere in the prison estate, and OMU case administrator shortages. At Chelmsford, there were delays of four months and at Erlestoke some prisoners had been waiting for up to 18 months. This caused mounting frustration and disillusionment. At Oakwood, some of the 126 category D prisoners at the time of our inspection had been waiting for almost two years to transfer. One prisoner told us:

> "I have been cat D for 20 months, but I can't get a transfer. It's all empty promises and feels like torture as I can't settle with them keeping on telling me I'll be going next week but it never happens. I can't settle and it's made even worse by my family not understanding why this is happening to me and I can't explain it to them". **Oakwood**

Long waits for interventions

After their suspension at the beginning of the pandemic, some offending behaviour programmes had been delivered, but with greatly reduced prisoner numbers and ever-rising waiting lists. In some prisons, such as Manchester, Hull and Swinfen Hall, many prisoners were not even receiving a programme suitability assessment that would enable them to join a waiting list. As a result, prisoners were continuing to be released without completing the offending behaviour work required by their sentence plans. A few establishments, such as Haverigg and Usk and Prescoed, had been active in managing this risk by liaising with COMs so that prisoners could complete a programme while on licence.

Uncertainty on release planning

Prisoners were often frustrated that their resettlement needs were not being met, and this was reflected in poor survey findings. For example, at Belmarsh only 38% of respondents said that someone was helping them prepare for release and at Thameside this was 41%, overall for male prisons this was 53%.

The unification of resettlement services under the umbrella of the Probation Service in June 2021 was intended to deliver more consistent provision, but had also created challenges and uncertainty. Under the new arrangements, prisoners assessed as very/high risk of harm had to rely on POMs and COMs to help them identify and address their resettlement needs. We found variable contact from COMs and at Hull there was major disruption to the delivery of resettlement services for high-risk-of-harm prisoners following the withdrawal of community rehabilitation company (CRC) staff.

Moreover, although external resettlement and probation staff had resumed face-to-face contact with prisoners in many establishments, some resettlement partners were still working remotely or were only seeing prisoners intermittently.

> Face-to-face support was not yet routine and prisoners were no longer able to drop in informally at the hub to access additional support and discuss their resettlement plans. **Chelmsford**

Resettlement plans remained of variable quality but were generally completed. Surprisingly, this was not the case at Swinfen Hall, even though many of the young adult prisoners had entered custody as children with no experience of independent living and were leaving without basic resettlement services.

Practical release arrangements were generally adequate; for example, most prisons had enough suitable clothing for prisoners who needed it, and some allowed them to charge their mobile phones before they left. Pre-release COVID-19 testing was also offered by some, but not all, establishments.

The use of release on temporary licence (ROTL) for resettlement purposes was still very limited, but some open establishments had made particularly good progress in providing this important opportunity to prisoners. For example, Prescoed had continued with ROTL throughout the community and regime restrictions, engaging 60% of prisoners.

Little support for remand prisoners and too many released homeless

The number of unsentenced prisoners had increased substantially, mainly because of lengthy pandemic-related court delays. At Chelmsford, the proportion of remand prisoners had doubled to almost 60% from just over 30% in 2018, and Thameside's population included 62% unsentenced prisoners – 61 had been on remand for over a year, the longest for 18 months. However, they were not given adequate resettlement support.

> ... the remand population no longer received support with housing or issues relating to finance, benefit and debt. This left the large number of remand prisoners without support to secure tenancies or deal with rent arrears. **Thameside**

Following the unification of the Probation Service and subsequent changes in the delivery of resettlement services, remand prisoners had not been included in new contracts with accommodation support agencies in prisons. This meant that even when specialist support was available in the prison they could not use it until the completion of a complicated referral process, originating from the COM.

> The St Mungo's (homelessness charity) worker provided advice and guidance on accommodation. However, they could no longer provide this service to unsentenced prisoners during the early part of their time in custody when a tenancy was most likely to be at risk. **Belmarsh**

At some prisons, around half of all prisoners were released homeless; at Wandsworth, only 45% of prisoners released in the previous year had accommodation arranged for their first night, while at Thameside the figure was 53%. The support given to such prisoners was too often inadequate. In our prisoner survey at Chelmsford, for example, only 5% said they were being supported with finding accommodation, even though 61% said they required it.

Table 9: Accommodation needs and support

	Do you need help finding accommodation when you are released?	Are you getting help to sort out finding accommodation when you are released, if you need it?
Local prisons	63%	31%
Category B training prisons	81%	41%
Category C training prisons	67%	48%
Young adult prisons	59%	62%
Open prisons	62%	53%
Overall	**64%**	**40%**

Prisons also continued to apply varied definitions of what was suitable and sustainable accommodation, and data collection on housing outcomes was often poor. For example, at Swaleside, staff tracked accommodation beyond release for six weeks, but did not record the type obtained or analyse the data, missing an opportunity to determine whether the accommodation met the needs of prisoners on release.

Northern Ireland inspection

HMI Prisons inspects prisons in Northern Ireland by invitation from the Criminal Justice Inspectorate Northern Ireland (CJINI). These inspections are conducted jointly with CJINI and other partner inspectorates in Northern Ireland. In May and June 2021, we inspected Magilligan Prison, holding about 400 medium-security, sentenced adult male prisoners.

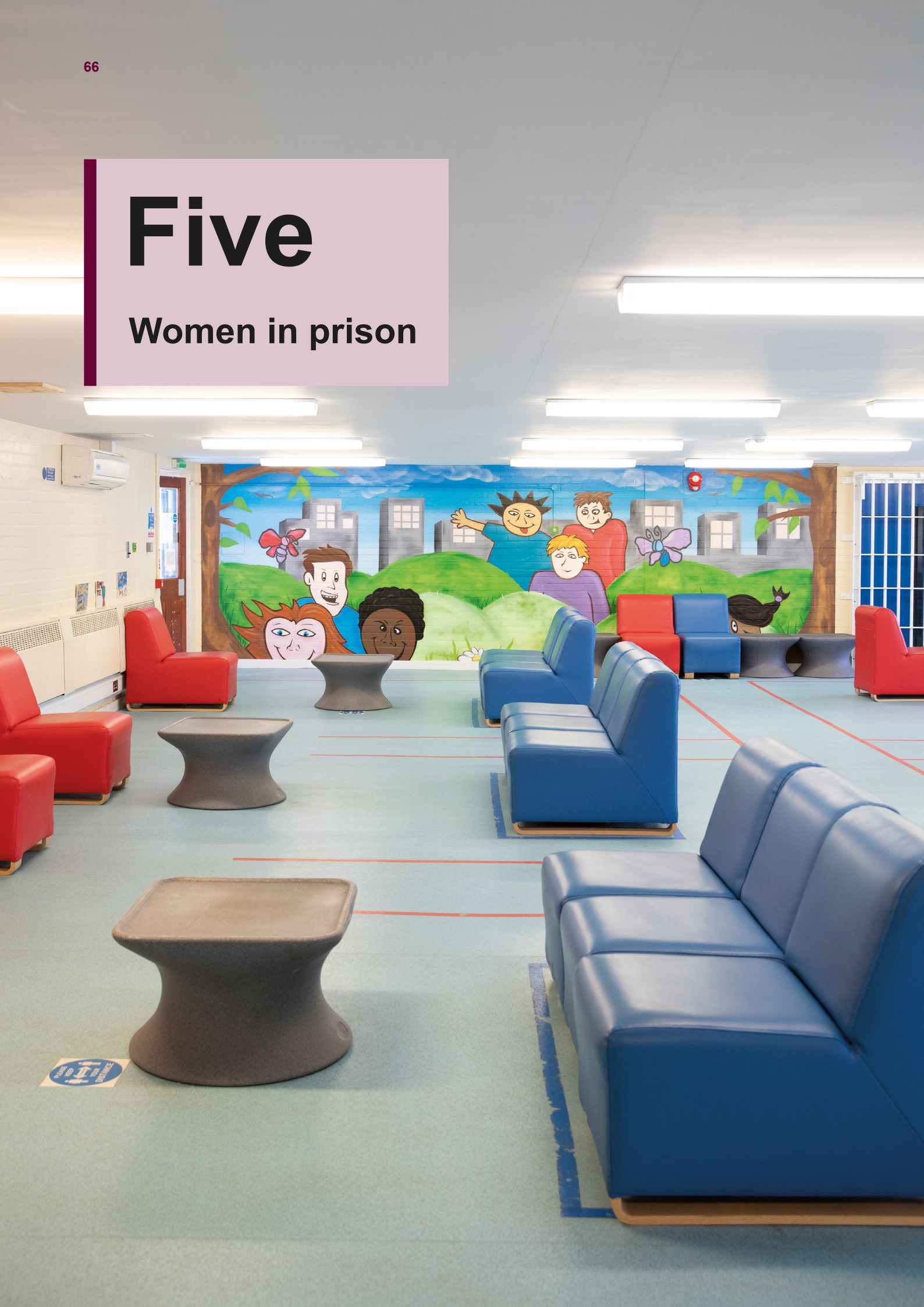
The inspection noted that, in marked contrast to prisons inspected in England and Wales, leaders at Magilligan had taken 'the early and brave decision to keep prisoners unlocked during much of the day while managing the pandemic', with a third of prisoners spending more than 10 hours out of their cell on a weekday. Despite this, there was a restricted regime and few opportunities for learning and skills development.

The prison was a safe environment with very little violence, but there was concern about the high number of illegal drugs coming in and being used, as well as the risk of diverted medications, with almost a third of prisoners saying they had developed a drug problem while there. We found generally good staff-prisoner relationships, and reasonable outcomes in resettlement work, but the accommodation needed renewal and higher standards of cleanliness.

Acknowledging the limitations imposed by the pandemic, inspectors called on the prison to show greater ambition in its approach to recovery.

Five

Women in prison



This section reviews the five inspections of women's prisons that took place since May 2021 – Downview, Foston Hall, Low Newton, Send and Styal – and identifies some of the key, differing needs of women in prison compared with men. The findings are based on our new **Expectations: Criteria for assessing the treatment of and conditions for women in prisons**, published in April 2021.

- Our prisoner survey results continued to highlight the differing needs of women compared with men. Mental health problems remained a far more prevalent issue for women in prison, with some sent there due to the non-availability of mental health facilities in hospital; the lack of data collection nationally meant the extent of this problem was unknown.
- Levels of violence had increased and, in some months, self-harm incidents were seven times higher than for men in prison. For a small number of women who self-harmed repeatedly, the better models of care provided active support for them.
- In our prisoner survey, women were more positive than men about staff-prisoner relationships, but those who said that staff treated them with respect varied between prisons from 62% to 85%.
- Many women left prison without a safe and sustainable place to live, but the extent of this problem was not fully apparent due to poor-quality data.

Table 10: Outcomes in inspections of women's prisons reported on in 2021–22

	Safety	Respect	Purposeful activity	Rehabilitation and release planning
Downview	Reasonably good	Not sufficiently good	Reasonably good	Reasonably good
Foston Hall	Poor	Reasonably good	Not sufficiently good	Reasonably good
Low Newton	Good	Good	Not sufficiently good	Reasonably good
Send	Good	Good	Not sufficiently good	Reasonably good
Styal	Reasonably good	Reasonably good	Reasonably good	Reasonably good

Outcome of previous recommendations

In the women's prisons reported on in 2021–22:

- the one previous main/key concern recommendation made in the area of safety had not been achieved
- in the area of respect, 50% of our previous main/key concern recommendations had been partially achieved and 50% were not achieved
- 33% of our previous main/key concern recommendations in the area of rehabilitation and release planning had been achieved and 67% not achieved
- there were no previous main/key recommendations made in the area of purposeful activity.

New Expectations for women in prisons

The second edition of our **Expectations** builds on what is known about women in prison and their differing needs. Key changes include:

- safe and healthy relationships between the staff and women now underpin our assessment of safety – these expectations promote the importance of staff knowing the women they are working with and adopting trauma-informed ways of working
- support to build relationships with children, families and others significant to them now leads our respect test, but also features in other sections, such as early days in custody
- we have integrated the importance of supporting women's well-being and recognising and responding to trauma throughout the four healthy prison tests, with an emphasis on supporting women to avoid reaching crisis.

Safety

One in five women prisoners surveyed felt unsafe at the time of our inspections, which was the same proportion as men. Support for them on arrival and during their first few days in prison was reasonably good and was best where there was peer worker involvement.

Good staff-prisoner relationships are a key factor in promoting safety for women. In our survey, 84% said they had a member of staff they could turn to for help and three-quarters felt that staff treated them with respect, which were both more positive than the 70% response from men. However, we found variations between the five prisons – in Low Newton and Send, 85% of women said staff treated them with respect but at Styal this was only 62%. Only 30% of women overall felt that staff understood their personal circumstances.

> They [wing staff] too often shouted down corridors to alert women to exercise or medication or used the Tannoy. Neither of these practices was helpful to the many women in the population who were dealing with previous trauma. **Foston Hall**

The rate of self-harm in 2021 was 4% down on the previous year at 3,697 incidents per 1,000 prisoners, which was more than six times higher than for men. A small number of women accounted for a large proportion of incidents and the better models of care were underpinned by targeted support for them, rather than solely relying on the reactive use of case-management documents (ACCTs, see Glossary). Day-to-day support for these women in some prisons was based on active engagement and care to avoid them getting into crisis, and provided support for their individual and often complex needs.

> The Stepping Stones programme provided very vulnerable women with recreational and social activities including arts and crafts, attending the gym together and relaxation techniques. This helped to improve their confidence in interacting with staff and other women and progressing into education, skills or work. **Styal**

Although levels of violence were lower than at men's prisons, they had increased. Most incidents were minor and were often caused by frustrations resulting from the pandemic restrictions, but also debt, relationship difficulties and bullying.

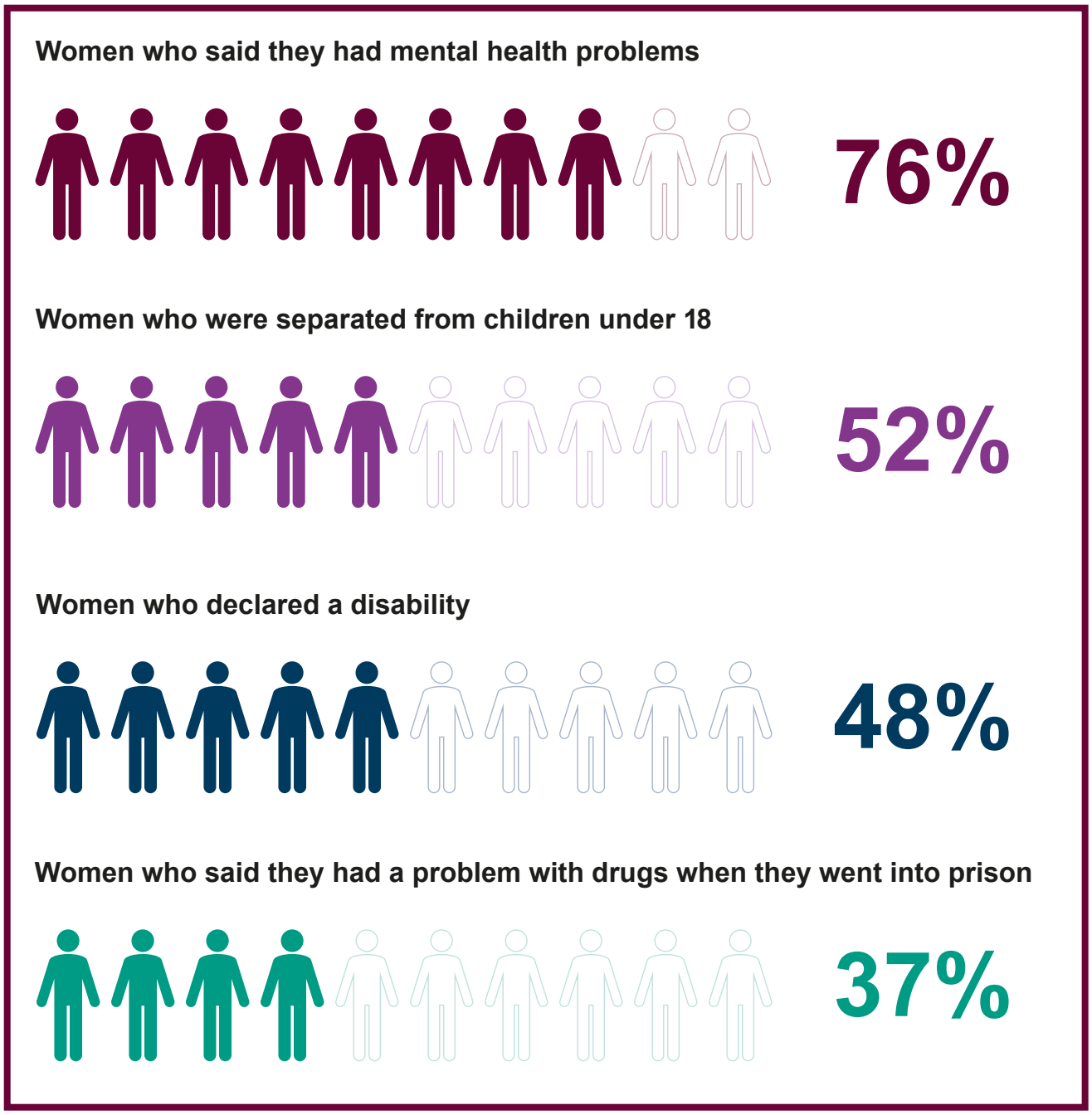
The level of mental health need was very high, with 76% of women in our survey reporting mental health problems. We continued to see examples of acutely unwell women being sent to prison due to the lack of places in mental health settings. With no data on this collected nationally, it was impossible to gauge the true extent of the problem. In some cases, unwell women ended up being segregated or located on the health care unit, often with inadequate specialist support. In one prison, decisions to segregate women were rarely challenged by other professionals, defensible decision logs were sometimes incomplete and ongoing segregation was not always justified.

> One segregation review said that the woman was to remain in segregation for concerns regarding current presentation and ongoing self-harm. **Foston Hall**

More women than men declared a problem with drugs and more said drugs were easy to get hold of. There was a need to provide up-to-date technology to detect secreted items.

Women in prison often have a high level of personal need

Results from our survey evidenced the high level and breadth of need for women in prisons. For example:



Respect

Much of the family work in women's prisons stopped when pandemic restrictions came in and was slow to reappear. Even when face-to-face visits resumed, uptake was low, but we saw some creative use of secure video calling.

> One woman regularly video called her five children in two different foster homes. Another saw her son in a secure hospital with the social worker attending. A third was able to video call her child's teacher during a school parents' evening for an update on their education. **Low Newton**

The prisons generally had pleasant outdoor areas and indoor areas were clean and in decent condition, but not all the residential houses at Styal were in good enough condition and in some 20 women had to share just two toilets.

There were weaknesses with the applications and complaints systems. While most women prisoners in our survey said it was easy to make an application, only 42% said they were dealt with in seven days. Some prisons lacked quality assurance systems.

> Applications were logged by unit staff, but responses were not tracked and managers did not have sufficient oversight of the process. In the applications books that we checked, very few responses were recorded. **Foston Hall**

In our survey, 45% told us that the quality of health care was good, but this varied from prison to prison.

All health care teams had vacancies that were being covered by agency staff. Access to health appointments was sometimes hampered by the lack of officers to escort women to and supervise clinics, which led to missed appointments.

In our survey, three-quarters of women told us they had mental health problems; just over half of those said they had been helped while in prison and half thought that the quality of mental health provision was good.

All pregnant women had access to a midwifery service and some had additional support while pregnant, but not all sites had a process to tell wing staff and keep them up to date about pregnant women and their expected delivery date.

Integrated substance misuse support was highly effective; in our survey, three-quarters of women with a drug problem said they had been helped while in the prison.

Equality and diversity work had been neglected and was slow to recover. For example, in our survey, almost half of women said they had a disability but only 39% of those said they were getting the support they needed.

Activity, education and work

As with men in prison, COVID-19 restrictions had led to a very poor daily regime with the majority of women locked in their cell for almost the whole day. We continued to see the detrimental impact of this on their well-being.

Few women reported regular access to the gym and library, but this varied between prisons, with those in training establishments more positive than those in local prisons. At Foston Hall, the library had not been open since the start of the pandemic and there was only one qualified PE instructor. At another we noted that:

> It was disappointing to find that the library service was poor, and access was inconsistent and limited for most prisoners. Most women living on Waite wing had not been to the library for more than a year. Time at the library was dictated by staff availability and, if prisoners were able to attend, their time was rushed and limited to only 30 minutes. **Styal**

The return to face-to-face learning and off-wing work had been slow. In-cell education packs were still used, but often without adequate feedback or measures to help women retain the knowledge gained. The quality of induction, advice and guidance for education, skills and work was too variable.

There was some long-term planning for work opportunities, for example, Send was working with external partners towards a coffee shop programme, including outside placements, and Low Newton had good external links. However, Send and Downview had made too little progress towards reintroducing previous external work placements.

Work in the prison continued to be a positive experience for women. Foston Hall set demanding standards for this but gave too little recognition of skills gained. Styal had maintained a network of local contacts during the COVID-19 restrictions to prepare for the resumption of work placements.

Women with additional learning needs were not always given enough support. At Send, it was left to individuals to signal their own needs, or for teachers to spot those struggling with in-cell learning. At Downview, however, education staff identified those with additional needs. Styal gave good support to those with further needs in education but not in work areas. Low Newton, having assessed women well, did better in supporting the learning of those with additional learning needs.

Resettlement

Most women had an up-to-date assessment of their risks and needs, and reasonably good contact with their prison offender manager. Public protection procedures were generally well managed and pre-release risk management planning had continued.

Release on temporary licence (ROTL) was still largely suspended. In some prisons the approach to using ROTL lagged behind the easing of restrictions in the community.

Access to offending behaviour work was variable and had been largely suspended during the pandemic restrictions, although there were positive examples of work to mitigate this in some prisons.

> The thinking skills programme (TSP) had restarted late in 2020 with facilitators offering adapted one-to-one sessions. The programmes team had prioritised women effectively using a range of criteria, including release date and individual need. No women had missed this intervention during the pandemic, which was positive. **Foston Hall**

Resettlement planning had been hindered by the changes made with the unification of the Probation Service, which led to the ending of contracts with community rehabilitation companies that had previously provided resettlement services and an ongoing uncertainty about future provision.

> Several months after major changes to resettlement services started, not all new providers were in place and models for delivery still lacked clarity. Women received different levels of support depending on their release area. A woman from one region, for example, might be able to open a bank account, while a woman from a different region could not. Not all providers had case workers regularly on site. **Styal**

Women on remand or not yet sentenced received little or no support as HMPPS did not contract the new service providers to deliver it.

Too many women were released homeless or to very short-term accommodation. The sustainability of housing outcomes for released women was not measured accurately at any of the sites, so it was impossible to assess the extent of the problem.

On a positive note, some women had the added benefit of mentoring on their release.

> Women In Prison, a national support charity, provided a good through-the-gate mentoring service. This involved women meeting mentors while they were still in custody... women who were assessed as presenting a high risk of harm could continue to receive support for up to 12 months after their release. **Downview**

Six

Children in custody

This section draws on a scrutiny visit (SV) to Parc young offender institution (YOI), full inspections of Cookham Wood and Wetherby and Keppel YOIs holding children aged 15 to 18, and three inspections of two secure training centres (Rainsbrook and Oakhill) holding children aged 12 to 18, with two further monitoring visits to Oakhill. Parc SV took place jointly with Estyn, and our full inspections and monitoring visits took place jointly with Ofsted and the Care Quality Commission (CQC). All the findings from inspections in this section are based on the fourth edition of **Expectations: Criteria for assessing the treatment of children and conditions in prisons**, published in November 2018, or **Joint inspection framework: secure training centres**, published in February 2014 and revised in March 2019.

- The number of children in custody fell to historical lows during the pandemic and had not increased meaningfully during 2021–22.
- Despite this, leaders and managers at all sites faced major challenges in recovering from the impact of COVID-19 and reintroducing education, offending behaviour programmes and resettlement provision.
- The most effective progress was made at Parc; in contrast, progress at other sites was much slower.
- Conditions for children in secure training centres (STCs) had deteriorated, leading to the issue of Urgent Notifications (see Glossary) at Rainsbrook and Oakhill.

Young offender institutions

Table 11: Outcomes in YOIs inspected in 2021–22

	Safety	Respect	Purposeful activity	Rehabilitation and release planning
Cookham Wood	Not sufficiently good	Not sufficiently good	Poor	Not sufficiently good
Wetherby/Keppel	Reasonably good	Reasonably good	Not sufficiently good	Not sufficiently good

Outcome of previous recommendations

In the YOIs reported on in 2021–22:

- 17% of our previous main/key concern recommendations in the area of safety had been achieved and 83% not achieved
- none of our previous main/key concern recommendations in the area of care had been achieved
- 50% of our previous main/key concern recommendations in the area of purposeful activity had been achieved and 50% not achieved
- 25% of our previous main/key concern recommendations in the area of resettlement had been achieved and 75% not achieved

Early days in custody

A new escort contract had resolved the longstanding issue of children waiting for long periods in court cells before transfer to the YOI. As a consequence, children no longer travelled in the same vehicles as adults and very few arrived late at their YOI. Children were generally treated well on reception and their first night, and there were procedures to ensure their safety.

All new arrivals had to isolate from other children and underwent a COVID-19 test on days two and six. If the result was negative, they could then mix with others. However, at Cookham Wood, delays posting tests meant many children were isolated for an unnecessarily long time.

With the exception of Parc, COVID-19 restrictions had reduced the effectiveness of children's induction into the establishment.

Safeguarding

All the establishments we visited had safeguarding protocols. Safeguarding teams in the YOI worked alongside local authority social workers and investigated all child protection allegations, most of which related to the use of force. As in previous years, some sites did not refer all incidents that met the threshold to the local authority designated officer for consultation and investigation.

Suicide and self-harm prevention

There were no self-inflicted deaths in YOIs in 2021–22 and there had been none since January 2012.

Levels of self-harm had reduced substantially at Cookham Wood and remained low at Parc. In contrast, they had risen at Wetherby and Keppel. This was, in part, due to the nature of the population on the Keppel unit, a national resource designed to support vulnerable children in custody. Most children at risk of self-harm felt well cared for. The quality of assessment, care in custody and teamwork case management documents (ACCTs) used to support these children was good at Parc, Wetherby and Keppel but had deteriorated at Cookham Wood, where quality assurance processes had failed to drive improvements.

Staff responses to emergency cell bells continued to be poor at most sites. In our survey, fewer than half the children at Cookham Wood, Wetherby and Keppel said that their cell bell was usually answered within five minutes. In contrast, at Parc this figure was 89%.

Managing behaviour

Levels of violence had risen and were high at Cookham Wood. In contrast, at Parc, Wetherby and Keppel violence was low and children's perceptions of safety were good. The organisation of children into small social groups in response to COVID-19 had led to conflict between these groups at Cookham Wood, where there was too much focus on keeping children apart rather than addressing the underlying conflict.

At Wetherby and Keppel, leaders were implementing measures to incentivise positive behaviour, including more time out of cell and opportunities to take part in army and fire cadets, Parkrun and release on temporary licence (ROTL). This was working in some areas but was undermined by inconsistent implementation. More positively, at Parc:

> The good relationships between children and staff underpinned behaviour management. We saw consistently good behaviour by children throughout our visit and many examples of staff encouraging children in their care to engage positively in the regime. **Parc**

The use of force

Use of force had fallen at all sites but remained high at Cookham Wood. Oversight arrangements were reasonably good, with trained staff and managers reviewing incidents. Staff use of body-worn video cameras during incidents had improved and footage from them was available in most that we requested to view. Pain-inducing techniques continued to be used inappropriately against children at Wetherby and Keppel; it was positive that these techniques had not been used in Parc for over a year.

Separation from normal location

Only at Parc did we find good outcomes for children held in separation. At the other sites we were concerned to see the continuation of some of the poor practice identified in our 2020 thematic report, **Separation of children in young offender institutions**. At Wetherby and Keppel, there was a lack of oversight of children separated on normal location. At Cookham Wood, practice fell well short of our expectations.

> Oversight of self-isolation and Rule 49 (good order or discipline) was lacking. The regime that separated children received was not recorded regularly, and when it was the regime provided was poor. In one case over a nine-day separation, the child did not leave his cell for four days, and on two other days he had left it for just 30 minutes. **Cookham Wood**

Relationships between staff and children

Relationships between staff and children had improved during the pandemic. They were mainly good at all sites and very good at Parc, where 94% of children in our survey felt cared for by staff. At Cookham Wood, while relationships were good on specialist units, staff expectations of children elsewhere were too low and we saw many examples of staff missing opportunities to interact with children during exercise or association.

Key work sessions had continued at Parc throughout the pandemic and had been restarted at Wetherby and Keppel at the time of our inspection. However, at Cookham Wood:

> There was no system to make sure that children had regular, meaningful contact with a named officer, and most residential staff we spoke to were not aware of children's progress in areas such as education and sentence plans. **Cookham Wood**

Daily life

Most children lived in accommodation that was designed for adult prisoners. In particular, the very large units accommodating up to 60 children at Wetherby hindered effective work. It was disappointing to find the worst living conditions at Cookham Wood, although it had some of the most modern accommodation in the estate – communal areas and cells were grubby, and there was extensive and offensive graffiti in cells, communal areas and exercise yards. By contrast, at Parc, Wetherby and Keppel staff regularly dealt with graffiti, and cells and communal areas were clean and tidy. Children at all sites had access to cleaning materials, clean clothing and bedding.

Children's perceptions of the food varied. While 77% of those surveyed at Parc said the quality was good, this fell to fewer than 40% of those at Cookham Wood and Wetherby. While we found the quality of food to be reasonable or better at all sites, children had very different experiences of mealtimes, ranging from eating most meals in their cells at Cookham Wood to always eating communally at Parc, with children at Wetherby and Keppel having a mixture of the two.

Equality and diversity

The responses to the pandemic had affected equality and diversity provision, with weaknesses at all sites. While the initial lack of face-to-face consultation was a reasonable response, there was little excuse for the ineffective use of data to identify and address potential discrimination.

> The collection of equality monitoring data to identify differences in treatment between protected groups had improved and some were shared at monthly safety review meetings. However, these data did not lead to useful investigations or follow-up actions into disproportionate outcomes for some children in protected groups.
> **Cookham Wood**

Discrimination complaints were dealt with appropriately at Parc, Wetherby and Keppel but investigations at Cookham Wood were poor and some did not take place at all.

Corporate worship had been suspended at all sites during the restrictions with chaplains limited to their statutory duties, some religious study groups and one-to-one pastoral support. Services had restarted when we inspected Cookham Wood, Wetherby and Keppel, but children were restricted to attending on a rota rather than every week.

Health care

Establishments continued to meet children's health needs during the pandemic restrictions. While there were additional waiting times because of the difficulty in getting children to their appointments, this was offset by health services that were well resourced and able to reschedule appointments promptly.

'Secure stairs', the framework for integrated health care (see Glossary), was curtailed by the lack of therapeutic space and social distancing for multidisciplinary teams to meet. A comprehensive range of mental health interventions was available to the children and they had good access to them. However, some very vulnerable children had unacceptable waits to transfer to secure mental health services due to the lack of available beds.

Purposeful activity

The greatest impact of the pandemic on children in custody was from the restrictions implemented by HMPPS on their time out of cell and access to education. All sites had had to limit their regime and deliver education and recreational activities in a different way. The very limited regimes we saw in 2020–21 had been improved, but children's experience differed considerably between the sites.

At Parc, most children spent almost 10 hours out of their cells on weekdays, and the weekend regime was similar and kept them occupied. At Wetherby and Keppel, they could expect five or six hours a day during the week and four hours at the weekend. Children at Cookham Wood, however, had an average of only four hours a day on weekdays and two hours at the weekend, which was unacceptable. These averages masked differences for children within establishments.

Parc takes a lead in time out for children

Local leaders had been proactive in recovery planning, liaising with the Welsh Government and Public Health Wales to deliver consistent improvements in access to education and other activities during the previous year. This successful planning had enabled children to spend nearly 10 hours out of their cell each weekday, including 4.5 hours of education, daily exercise and evening association. This was far better than at other YOIs.

Although children had regular time in the open air, facilities were rudimentary at all sites. Parc had brightly painted exercise yards in a good condition, but they were small. The yards at Wetherby were stark with no equipment and at Cookham Wood most exercise yards were in a poor condition.

PE provision was good across the sites with children having a regular opportunity to take part in physical activity.

> There were five separate gyms around both sites, and all children had access to a well-appointed gym. Ten physical education instructors and eight sports and games officers provided a wide range of activities and delivered vocational training with several community agencies. **Wetherby and Keppel**

Education

Parc had provided very effective education throughout the pandemic restrictions, which had involved children and enabled them to progress in their learning. They had been able to attend workshops or classes for a minimum of two hours each weekday from the end of March 2020 and this had increased over the following year.

Ofsted judged outcomes to have declined at Cookham Wood, Wetherby and Keppel. At Cookham Wood, education hours had been reduced to 12 a week. Attendance was poor and children felt frustrated, justifiably, that they spent too much time in their cell without doing anything purposeful.

At Wetherby and Keppel, the governor's vision was to provide 15 hours of formal education and 12.5 hours of community learning a week. However, leaders were not clear about what activities would comprise the community learning component of the curriculum. This meant that teachers were left to plan and deliver sessions that lacked purpose, and too many children did not gain any tangible benefits.

Contact with the outside world

The pandemic had a negative impact on children's ability to maintain contact with their family and friends. In our survey, only 8% of children in YOIs said they received visits once a week or more. The reasons for this included the long distances most families had to travel, reduced availability of visiting times and concerns about health and safety. Although secure video calls were available at all sites, uptake was generally low. Children told us this was because of the difficulties in booking them, the environment in which they took place and a preference for phone calls. At Cookham Wood, there had been only 34 video calls out of 404 potential slots in July 2021. In contrast, at Wetherby and Keppel:

> Prison managers had made very good use of the secure video calls facility... An average of 430 took place each month, which was excellent. Although no substitute for visits in person, this facility supported children to keep in touch with friends and family. **Wetherby and Keppel**

Sentence progression and risk management

Children's engagement with their sentence or remand plan varied, with many not knowing they had a plan or any objectives. Caseworkers at all sites made sure that training and remand planning review meetings took place regularly. However, there continued to be a disconnect between sentence planning and day-to-day care of children. Residential staff were often unaware of a child's plan and rarely attended reviews for those in their care.

Public protection arrangements were not good enough at Cookham Wood, Wetherby and Keppel, where the interdepartmental risk management team meetings were not functioning properly. There were also considerable delays in phone monitoring at Wetherby and Keppel.

Release planning

The longstanding problem with accommodation not being arranged in good time before a child was released undermined release planning in other areas, including health care and education, training and employment. But at Parc, despite these difficulties, every child left with an education or training place to attend. In contrast, this data was not collected at Cookham Wood, and at Wetherby and Keppel around 40% of children left with no activity arranged.

Girls in custody

The failure nationally to plan and implement an effective arrangement for the small number of girls held in custody meant that the estate was unable to accommodate five girls who had to be moved when children were removed from Rainsbrook STC in 2021 (see below). The refusal by secure children's homes to take these girls led to Wetherby having to accommodate them at short notice. There is still no placement available in the children's estate for pregnant girls and new mothers.

Leaders at Wetherby had prepared well for their care. At the time of our inspection, three girls were held on the Napier unit. The care they received from staff was good and when we inspected they were taking part in education and other activities.

But important differences in outcomes remained; girls were more likely to self-harm, be subject to use of force and receive less time out of their cell than boys. Boys at Wetherby noticed the difference in the treatment of girls, including the ability to wear their own clothes – a decision which had not yet been extended to the boys – and this needed to be addressed.

Secure training centres

Table 12: Outcomes in inspections of STCs 2021–22

	Oakhill	Rainsbrook
Overall experiences and progress of children and young people	Inadequate	Inadequate
Children's education and learning	Requires improvement	Inadequate
Children's health	Good	Inadequate
Children's resettlement	Requires improvement	Requires improvement
How well children and young people are helped and protected	Inadequate	Inadequate
The effectiveness of leaders and managers	Inadequate	Inadequate

Previous inspections over several years have outlined the need for significant improvement in standards at STCs. We inspected both sites, Rainsbrook and Oakhill (which also had one prior and one subsequent monitoring visit), and found conditions for children had deteriorated. Both sites were graded inadequate overall and the joint inspectorates invoked the Urgent Notification process for both. This was the second time an Urgent Notification had been issued for Rainsbrook within a year – the first occasion followed a monitoring visit in December 2020 that found there had been little improvement in remedying the serious concerns previously highlighted by the inspectorates. The Secretary of State took the decision to remove all children from Rainsbrook in June 2021.

Violence between children and towards staff at the STCs was unacceptably high, as was the use of force. At Rainsbrook, we saw some improvement in the governance of force, but at Oakhill we found examples of unjustified and excessive force used on children.

Child safeguarding at Rainsbrook lacked the capacity to implement the changes needed to improve the protection of children. At Oakhill, children were not adequately protected due to serious failures in the management of child protection and safeguarding referrals; this failure was so acute that children may have been exposed to avoidable ongoing harm, and others could have been experiencing unidentified harm at the time of the inspection.

High staff turnover had a negative impact, preventing children from forming meaningful relationships with staff due to the frequent changes. Staff at both sites lacked the experience to deal with challenging behaviour, which led to frequent fights and use of force. At Rainsbrook, we also found evidence of poor supervision that had led to security breaches; children were gaining entry to areas that should have been restricted, often to assault or bully other children. Neither site had effective behaviour management systems.

Living areas in both centres needed improvement: Rainsbrook did not always maintain a welcoming, child-friendly environment, and at Oakhill we found ripped sofas and damaged tables in communal areas, and many toilets and showers were stained and dirty.

Education and learning required improvement to be good at Oakhill; children were assessed well but the curriculum did not meet their needs. At Rainsbrook it was inadequate, the learning environment was poor, children were frequently late for class and often did not know what class they were attending. Leaders had failed to prioritise children's learning.

Resettlement was a slightly better picture, requiring improvement to be good at both sites. Children were aware of their sentence plan targets but release planning was less effective; some children at the two centres could not plan for their future education or training as they were unaware of where they would be living until their day of release.

At a subsequent monitoring visit to Oakhill in November 2021, we found that progress had been made in stabilising the centre, but concerns remained.

Seven

Immigration detention

This section reports on a scrutiny visit (SV) to Harmondsworth immigration removal centre (IRC) and a full inspection of Dungavel IRC, and inspections of three detention facilities holding migrants on the south coast – Tug Haven and Kent Intake Unit in Dover and Frontier House in Folkestone. We also report on inspections of three residential short-term holding facilities (STHFs) at Manchester, Larne (Northern Ireland) and Yarl's Wood (Bedfordshire), and two overseas charter flight removals. We postponed a further two planned IRC inspections as a result of significant COVID-19 outbreaks in the centres. All our findings are based on the fourth edition of our **Expectations: Criteria for assessing the conditions for and treatment of immigration detainees**, published in January 2018.

- IRCs managed the pandemic well but too many detainees were held for lengthy periods with little prospect of removal, including many considered to be vulnerable under the Home Office's 'adults at risk in immigration detention' policy.
- The south coast detention facilities remained unfit for purpose and progress to replace them had been too slow.
- Conditions for detainees in residential STHFs were good, but we found some weaknesses in safeguarding.
- The two overseas removals inspected were largely without incident, but the escort contractors had not reviewed some disproportionate practices in light of reduced risks.

The changing face of immigration detention

We have seen some major changes in immigration detention this year. The pandemic had otherwise limited the number of people held in IRCs and the centres had populations much below their capacity, although sections of all were used to hold migrants who had arrived across the English Channel in small boats. By contrast, we saw very high numbers of people, including children, held in the south coast detention facilities.

The number of people detained in prisons solely under immigration powers rose sharply in 2021–22, increasing by 31% when compared with the previous year. In view of this, we are undertaking a short review to look at the treatment and conditions of detainees held in prisons compared with those in IRCs.

In 2021–22, 25,282 people entered immigration detention. Although this was almost double the previous year, it followed a large fall in the number of people entering detention during the first wave of COVID-19 in 2020, and is now 9% higher than before the pandemic in 2019–20. On 31 March 2022, there were 1,440 people in immigration detention, including those detained solely under immigration powers in prison (these figures do not include those held for short periods in non-residential STHFs).

Immigration removal centres

Managing COVID-19 risks

Our IRC visits took place before the emergence of the Omicron variant of COVID-19 at the end of 2021, and there had been few cases of the infection. At the time of our visits, there had been only eight positive detainee cases at Harmondsworth and just one at Dungavel since the start of the pandemic.

Health risks had been managed at both centres through good leadership and effective partnership working with the Home Office and health providers. Health information was available to detainees in several languages and the roll-out of the national COVID-19 vaccination programme was well coordinated, although take-up was low at Harmondsworth. Cohorting arrangements to minimise the risk of transmission were managed well at both centres. The low number of detainees meant that they were generally accommodated in single rooms or cells, which helped to prevent the spread of the virus.

> Managers had focused well on informing detainees of the measures taken to protect them from COVID-19 and the reasons for the restrictions in place. Centre and health care managers had provided a good range of translated information and newly arrived detainees now received an innovative virtual reality induction delivered in several languages. **Harmondsworth**

The impact of detention

Some detainees were still held for long periods at both centres, especially at Harmondsworth where eight people had been in detention for over a year and 26 for more than six months. There was little prospect of removal in many cases because of pandemic-related travel restrictions, and most detainees (58%) held at Harmondsworth during the six months before our inspection were simply released after a potentially damaging and unnecessary period of detention. Many people at both centres were also held in detention because of a lack of suitable accommodation.

> At the beginning of the inspection, 13 individuals had been granted bail but remained in detention pending a suitable release address. Three had been waiting for accommodation for more than six months. Two detainees with learning disabilities, one of whom had been assessed to lack mental capacity, had been waiting for bail accommodation for over six months. **Harmondsworth**

Detainees were often considered vulnerable: about 45% of the population at Harmondsworth were assessed at the two higher levels of vulnerability under the Home Office's adults at risk policy. Many detainees we interviewed said they had mental health problems and that they had felt depressed while at Harmondsworth. At both centres, detention was maintained in some cases where health professionals considered people to be unfit for detention. There was also a high level of self-harm at Harmondsworth, although most at-risk detainees subject to assessment, care in detention and teamwork (ACDT) case management were reasonably positive about the care they received.

Safety and living conditions

There were few violent incidents in the centres. Oversight and control of the use of force by staff were good in Harmondsworth, but less rigorous in Dungavel, although use of force was infrequent in both centres. While Dungavel provided a generally safe environment, during the pandemic it held some detainees with a history of violence against women, which meant that women held at the same time had to be escorted around the site. Care for vulnerable detainees there was good.

> Since the previous inspection, the centre had opened a supported living unit, which provided a calm environment for vulnerable detainees. Detainees accommodated there could move around the centre, eat with their peers and use centre facilities.
> **Dungavel**

The physical environment at Dungavel had improved following significant investment in the residential units and other parts of the centre. However, Harmondsworth was still prison-like, with run-down living areas and detainees locked in their cells for long periods. The general environment was bleak and dispiriting, and managers told us that there was a lack of investment for the refurbishment that was clearly needed.

Many detainee custody officers at Dungavel continued to complain of low morale and understaffing. While we saw no evidence that this discontent had yet affected the treatment of detainees or safety in the centre, it had the potential to become a more significant concern as the population increased, and it required sustained leadership attention.

Short-term holding facilities

South coast facilities not fit for purpose

In November 2021, we inspected Tug Haven, the Kent Intake Unit (KIU) and Frontier House on the south coast, which were all predominantly used to accommodate migrants who had undertaken sea crossings from France. Despite some improvements since our inspection of these sites in 2020, conditions remained unacceptably poor and progress on opening new, larger facilities had been too slow. The rise in the number of people making Channel crossings had not been a surprise and much more should have been achieved in the year since our previous inspection.

At Tug Haven, we saw several people who arrived with significant injuries and illnesses, but the site was ill-equipped to meet their needs. Migrants had little private space and were sometimes held overnight, sleeping on the ground, often in wet clothes. The holding rooms at the KIU and Frontier House were small and did not have adequate sleeping facilities.

The time that people were held at these units had increased and many detainees – including unaccompanied children – spent several days there without access to adequate washing facilities, beds or time in the open air. Detainees and some detention staff had become very distressed by the unacceptable conditions in which they were held.

> Detainees were confined to a permanently lit room without access to fresh air or even the chance to look outside because of the frosted windows. We observed 40 people in the holding room, barely able to move and unable to rest properly after exhausting journeys. **Kent Intake Unit**

Families, women and children were held for long periods, sometimes days, alongside unrelated men, and in several cases detainees with severe health problems or experiences of trauma were detained without adequate support. While social workers had been brought into the KIU to conduct age assessments, their skills were not used to support children or vulnerable adults.

Residential STHFs: good accommodation but weaknesses in safeguarding

At Larne, Manchester and Yarl's Wood residential STHFs, we found decent living conditions, especially at Yarl's Wood, and good management of the risks posed by COVID-19. There was also a positive focus on the safety of detainees and adequate support systems for those at risk of self-harm. However, detainees had little understanding of what was happening or would happen to them, in part due to a lack of translated information.

At Yarl's Wood – mostly used to accommodate arrivals from the south coast while they underwent the initial asylum screening process – we found a lack of oversight of who was being transferred to and held at the centre, and delays in critical processes to identify risk and vulnerability.

Many detainees arrived at the centre with incomplete paperwork, often without a risk assessment. They were not given a Home Office screening interview or told the reasons for their detention until several days after their arrival.

We also found instances of unaccompanied children wrongly transferred to Yarl's Wood and several cases where detention exceeded the legal limit for residential STHFs of five days.

> ... 15 children had arrived at Yarl's Wood from Dover since the beginning of 2020, not having been identified as such at the coast... almost half of the 31 age assessments during that time, on detainees who claimed and/or appeared to be under 18, confirmed that the person was a child. **Residential Short-Term Holding Facilities**

Overseas escorts

We inspected one flight that removed 22 detainees to Lithuania and another that took nine detainees to Spain and Portugal. These were the first removals we have inspected since the United Kingdom's withdrawal from the European Union and therefore from the Dublin Convention (see Glossary).

The collection and removal of detainees from IRCs was managed efficiently but there was sometimes an insufficient focus on individual needs. For example, documentation for the removal to Lithuania did not always convey the information needed to assess detainees' current risks and vulnerabilities, and instead relied heavily on their previous criminal convictions.

Many detainees we spoke to were also frustrated about the absence of specific information on collection and flight times, or on how they could travel to their final destination.

Detainees were generally compliant and both removals were largely free of incident and managed well. However, despite the high level of cooperation from detainees and their assessed low risk, some unnecessary removal practices continued. For example, 'guiding holds', which entailed routinely laying hands on detainees while escorting them, were more likely to escalate than reduce tensions. Detainees were also still subject to unwarranted indignities.

> ... some practices remained disproportionate, including detainees not being permitted to close toilet doors, an intrusion on privacy that could not be justified by the assessed risks. **Removal to Spain and Portugal**

All detainees and escorting staff were required to provide negative COVID-19 tests before the flights. Staff and most detainees wore face coverings, but social distancing was inconsistent and sometimes impossible to achieve in the confined space of the aircraft.

Eight

Police custody

In March 2020, HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) suspended joint inspections of police custody. HMI Prisons and HMICFRS agreed that, in line with its statutory responsibilities, HMICFRS would lead the inspections when they resumed in May 2021, with HMI Prisons assisting by inspecting the physical environment, detainee care, health and arrangements for court, and jointly inspecting the use of force.

During 2021–22, we reported on custody facilities inspected in four police forces: Cleveland, Kent, Warwickshire and Surrey.

- Conditions in police custody suites were generally good and most detainees were positive about their treatment by staff.
- Health care generally met detainee needs, including for those with mental ill-health, but there were still delays in finding hospital beds for some who needed them.
- There were some weaknesses in the oversight and use of force against detainees.

The provisions to make sure detainees were looked after properly in custody varied. We expect these to include regular offers and supply of suitable food and drinks, access to showers/washing facilities and clean clothing if needed, as well as access to fresh air and activities to keep them occupied during their stay. We found that custody staff did not always actively offer and provide access to facilities and some care provision. Detainee care was generally reasonably good, except for Cleveland where it was poor.

The conditions and cleanliness in all the suites were good. However, we found potential ligature points in the custody facilities in four out of five inspected forces.

Although there were governance and oversight arrangements for the health care provided, the emphasis was sometimes on contract delivery rather than evaluating the detainee experience of health care support. Nevertheless, health care professionals generally met detainees' health needs well. There was reasonable support for detainees with substance misuse needs, although in Surrey they were unable to continue with opiate substitution treatment.

Police officers are only permitted to take into custody those detained under section 136 of the Mental Health Act 1983 in exceptional circumstances. We continued to find very few instances of this happening, and the provision for those experiencing mental ill-health who were detained was generally good. But for those entering custody who required a Mental Health Act assessment, there were often long waits and further delays in finding a hospital bed.

Force should only be used against detainees as a last resort, and should be necessary and proportionate to the threat or risks posed. This was the case in most incidents we reviewed but was a cause of concern in Cleveland and North Wales. Weaknesses in the use of force in custody included inaccurate data and poor oversight, and we had concerns about how force had been used against some detainees. In some facilities the forcible removal of clothing was commonplace, often with poor rationale for such decisions. In most cases the removal of clothing was unnecessary and risks could have been better managed through higher levels of observation. There was little consideration of the impact on detainees of such intrusive processes, which we expect only in extreme situations. In a minority of cases, we were not assured of the necessity for and proportionality of some of the force used, and referred several cases back to the police to review.

Detainees generally attended court promptly. The courts were often flexible in dealing with detainees who arrived in police custody later in the day if they were still sitting and had capacity to hear their case. Most detainees were presented before the first available court, which reduced their overall time in custody.

Nine

Court custody

All the findings from inspections in this section are based on the second edition of **Expectations for court custody: Criteria for assessing the treatment of and conditions for detainees in court custody**, updated in March 2020. This section draws on inspections of custody facilities in two court clusters: Cleveland, Durham and Northumbria, and Central and South London.

Our inspections of court custody consider areas that affect outcomes for detainees. These include leadership and multi-agency relationships, transfer to court, reception processes, individual needs and legal rights, the physical environment, detainee care, use of force, safeguarding, health, and release or transfer procedures.

- Multi-agency leaders did not always work together effectively to achieve good outcomes for detainees.
- Staff did their best to meet detainee needs, but there was a lack of provision, including for some groups. Detainees were, however, complimentary about their treatment.
- Physical conditions suffered from a lack of investment and remained poor.
- Care for children in custody had broadly improved, as had health provision for all detainees, and handcuffs were now only used following risk assessment.
- Release arrangements were reasonable, but some detainees spent longer than necessary in custody.

Leadership and multi-agency relationships

The provision of court custody relies heavily on the collaboration and cooperation between three main stakeholders: Her Majesty's Courts & Tribunals Service (HMCTS), Prisoner Escort and Custody Service (PECS) and the contracted provider – GEOAmey in Cleveland, Durham and Northumbria and Serco in London. The throughput of detainees in custody was almost back to pre-pandemic levels when both clusters were inspected. Striking the balance between delivering court business and dealing with detainees promptly and effectively was a continuing challenge.

In both areas, the leadership teams were focused on delivering good outcomes for detainees but this was not achieved consistently. COVID-19 had undoubtedly contributed to some of the weaknesses in management, as engagement and communication, particularly face to face, had been very limited and oversight in custody facilities had reduced.

> The multi-agency arrangements to make sure that outcomes for detainees were consistently good were not always effective: meetings had lapsed, audit regimes were almost non-existent, communication was sometimes too limited and escalation processes were not widely known about or used. **Cleveland, Durham and Northumbria**

The collation and use of data to inform organisational learning and practice were underdeveloped and lacked rigour in both regions.

Staffing arrangements in London were problematic. Many facilities had no manager and consequently were often chaotic environments. Training and development of staff in both areas were weak, and understanding and implementation of learning were rarely checked.

Transfer to court

By the time we inspected facilities in London, a new fleet of escort vehicles was in place across England and Wales. They were clean and well equipped and offered a safer and more comfortable journey for detainees. Disappointingly, both inspections found that women often shared transportation with men and were not always adequately protected from verbal abuse, which was unacceptable.

Individual needs and rights

Detainees were usually treated with respect. Staff often did not have enough training or resources to provide specific and informed care for different groups but generally did their best to meet individual needs. Provision was, however, often lacking for detainees with disabilities, and staff rarely used telephone interpreting services to communicate with those who spoke little or no English. Treatment of women and detainees practising a religion was generally better than previously, and there was some good awareness of people with neurodivergent conditions in some of the facilities in London.

There was a reasonably good approach to the identification and management of risk. Staff were alert to signs of vulnerability, set appropriate levels of observation and mostly completed checks at the required frequency.

Attention to meeting detainees' legal rights was adequate overall. Although there was a strategic and judicial commitment to prioritising the hearings of those in custody, this was not always achieved and was compounded by a range of factors that sometimes contributed to detainees spending longer in custody than necessary. It was disappointing that the main stakeholders were not focused on or taking action to address these issues.

In the custody cell, safeguarding and health care

A notable concern in both inspections was the poor conditions in which detainees were held. Cells were often grubby, had graffiti (some offensive) and potential ligature points. Custody suites often lacked sufficient investment to make them decent environments for both detainees and staff.

Positively, in both inspections we found that staff de-escalated potentially volatile situations well and used force against detainees relatively infrequently. After many repeated recommendations, changes to the newest contract for the delivery of court custody meant that arrangements for handcuffing detainees were now proportionate, and this generally only happened when supported by a risk assessment.

Detainees were mainly well looked after in court custody and most were complimentary about their treatment. The provision of food and drinks was broadly adequate, although a better range was available in Cleveland, Durham and Northumbria. Most facilities stocked some limited activities to help detainees pass their time but these were not given out routinely, which was a missed opportunity.

> Some detainees went out of their way to tell us how well they had been treated and some contrasted the helpful behaviour of custody staff with the formality of the rest of the process that they had experienced. **Central and South London**

A further improvement brought about by the new contract was the provision of enhanced care for children, which included non-cellular vehicles and specially trained staff to accompany children and look after them in court custody. The provision was well embedded and more consistent in Cleveland, Durham and Northumbria. In London, arrangements were greatly affected by lack of staffing and the numbers of children held in court custody – over 1,500 in the year before the inspection. This resulted in care for some that was barely different from that offered to adults. Positively, most custody staff now had a basic understanding of safeguarding policy and practices.

There were generally responsive arrangements to meet detainees' physical health care needs in both areas, and these had continued to improve as health providers established themselves as a resource for both custody staff and detainees. Specialist mental health support was less consistent in Cleveland, Durham and Northumbria. In London, liaison and diversion staff worked closely with community agencies, which meant that access to services was well coordinated and focused on individual needs and diversion from custody where appropriate. Specialist mental health support at Crown courts was being commissioned and was developing rapidly.

Release and transfer from court custody

Custody staff generally took reasonable care to make sure that detainees were transferred or released safely when they had finished in court, providing support to those without the means to have a safe onward journey.

Most detainees in Cleveland, Durham and Northumbria were released quickly on conclusion of their cases. Unusually and inexplicably, some detainees in London were locked back in cells and experienced unnecessary delays in being released.

In both regions, many detainees who had originated from a prison and were then released by the court were deprived of their liberty for too long while waiting for a formal authority from the prison to release them. Not enough was done to escalate the issues as they arose or to understand the extent of and address the problem.

Ten

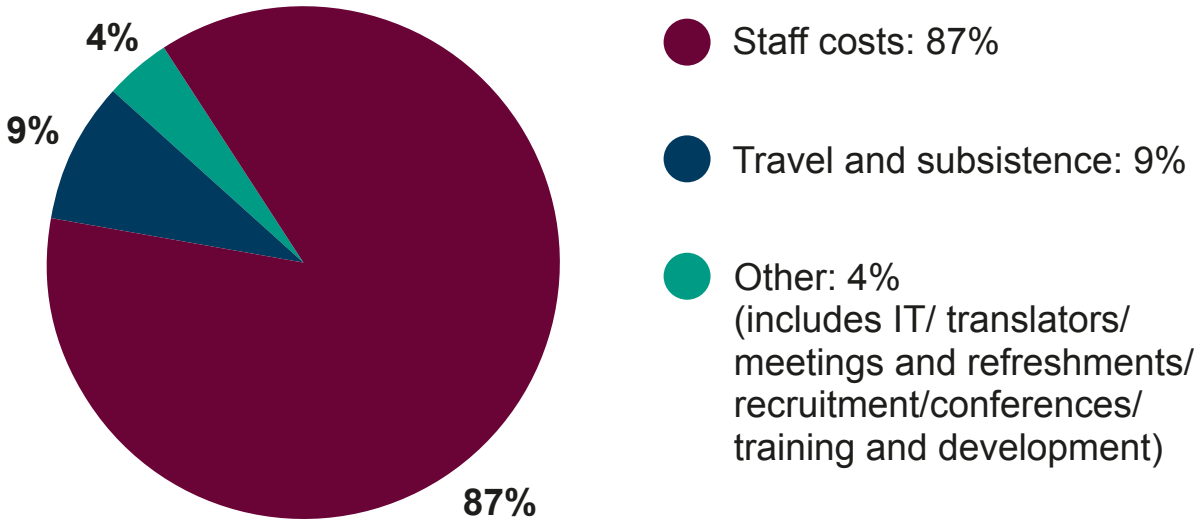
The Inspectorate in 2021–22

Income and expenditure – 1 April 2021 to 31 March 2022

Income	£
Ministry of Justice (prisons and court cells)	4,570,000
Home Office (immigration detention)	352,220
Home Office (HMICFRS/police custody)	285,000
Youth Justice Board/Youth Justice Commissioning Team (YJCT) (children's custody)	119,866
Other income (HMI Probation, Prisons and Probation Ombudsman, STC, Ministry of Defence, Border Force)	163,340
Total	**5,490,426**

Expenditure	Total (£)	%
Staff costs Note: Staff, fee-paid inspectors, secondees and joint inspection/partner organisations costs e.g. General Pharmaceutical Council and contribution to secretariat support of the Joint Criminal Justice Inspection Chief Inspectors Group.	4,581,265	87
Travel and subsistence Note: Reduced in the field activities were undertaken due to COVID-19 until May when regular inspections were restarted. Activities were subject to heightened risk assessment, and cancellations and delays occurred throughout the year.	491,900	9
Printing and stationery	19,222	0.37
Information technology and telecommunications Includes the cost of renewing scanning hardware and licenses to software (SPSS and SNAP – used by researchers to process and analyse survey data) and additional equipment required by office-based staff working from home due to COVID-19.	80,330	1.53
Translators	13,912	0.26
Training and development	20,211	0.38
Others (including recruitment costs, conferences and professional memberships)	58,415	1.11
Total	**5,265,255**	**100**

Expenditure 1 April 2021 to 31 March 2022



Inspectorate staffing – 1 April 2021 to 31 March 2022

Our staff and fee-paid associates come from a range of professional backgrounds. While many have experience of working in prisons, others have expertise in social work, probation, law, youth justice, health care and drug treatment, social research, and policy. Most staff are permanent, but we also take inspectors on loan from HMPPS and other organisations. We engage associates based on their expertise in areas we inspect to enhance our employed staff. Currently, eight staff are loaned from HMPPS, and their experience and familiarity with current practice are invaluable to our work.

Staff engagement

Every year we gather feedback from our staff. In 2021, we once again participated in the Civil Service People Survey, commissioned by the Cabinet Office. The survey was completed by 62% of HM Inspectorate of Prisons staff and the results indicated a score of 76% on the overall staff engagement index. In 2021 86% of staff completing the ‘my work’ section of the survey said that work gave them a sense of personal accomplishment and was sufficiently challenging, and 88% of staff answering the ‘organisational objectives’ section said that they had a clear understanding of the organisation’s objectives and purpose and understood how their work contributed to them.

Staff and associates – 1 April 2021 to 31 March 2022

	Charlie Taylor	**Chief Inspector**
	Martin Lomas	Deputy Chief Inspector
	Barbara Buchanan	Senior Personal Secretary to the Chief Inspector
A Team (adult male prisons)	**Sara Pennington**	**A Team Leader**
	Natalie Heeks	Inspector
	Martin Kettle	Inspector
	Jade Richards	Inspector
	Paul Rowlands	Inspector
O Team (prisons holding women)	**Sandra Fieldhouse**	**O Team Leader**
	Rebecca Stanbury	Inspector
	Jonathan Tickner	Inspector
N Team (adult male and young adult prisons)	**Deborah Butler**	**N Team Leader**
	Ian Dickens	Inspector
	Alice Oddy	Inspector
	David Owens	Inspector
	Nadia Syed	Inspector
Y Team (establishments holding children)	**Angus Jones**	**Y Team Leader**
	David Foot	Inspector
	Angela Johnson	Inspector
	Esra Sari	Inspector
	Donna Ward	Inspector
I Team (immigration detention)	**Hindpal Singh Bhui**	**I Team Leader**
	Rebecca Mavin	Inspector
	Tamara Pattinson	Inspector
P team (police custody)	**Kellie Reeve**	**Acting P Team Leader**
	Fiona Shearlaw	Inspector

Health Services Team	**Tania Osborne**	**Head of Health and Social Care Inspection**
	Steve Eley	Health and Social Care Inspector
	Shaun Thomson	Health and Social Care Inspector

Research, Data and Thematics	**Sophie Riley**	**Head of Research, Data and Thematics**
	Rahul Jalil	Senior Research Officer
	Helen Ranns	Senior Research Officer
	Charlotte Betts	Research Officer
	Amilcar Johnson	Research Officer
	Alec Martin	Research Officer
	Joe Simmonds	Research Officer
	Rachel Duncan	Research Assistant
	Emma King	Research Assistant
	Isabella Raucci	Research Trainee
	Elenor Ben-Ari	Research Trainee

Secretariat	**Jane Boys**	**Head of Secretariat**
	Lesley Young	Head of Finance, HR and Inspection Support
	John Steele	Chief Communications Officer
	Lucy Gregg	Head of NPM Secretariat
	Jade Glenister	Head of Policy
	Billie Powell	Policy Officer
	Tamsin Williamson	Acting Head of Communications
	Hannah Baker	Publications and Digital Communications Officer
	Amelia Horn	Publications Assistant
	Reeta Jobanputra	Communications Officer
	Umar Farooq	HR and Inspection Support Manager
	Stephen Seago	Finance and Inspection Support Manager
	Caroline Fitzgerald	Inspection Support Officer
	Serife Suleyman	Inspection Support Officer

Fee-paid associates	Liz Calderbank	Inspector
	Anne Clifford	Editor
	Sarah Goodwin	Health Inspector
	Martyn Griffiths	Inspector
	Jeanette Hall	Inspector
	Deri Hughes-Roberts	Inspector
	Keith Humphreys	Inspector
	Maureen Jamieson	Health Inspector
	Brenda Kirsch	Editor
	Sally Lester	Inspector
	Ali McGinley	Inspector
	Stephen Oliver-Watts	Inspector
	Adrienne Penfield	Editor
	Yasmin Prabhudas	Editor
	Christopher Rush	Inspector
	Paul Tarbuck	Inspector
	Dionne Walker	Inspector
	Nisha Waller	Researcher
	Karen Wilson	Health Inspector

Staff and associates who left this reporting year	Heather Acornley	Research Trainee
	Tanveer Ali-Azhar	Inspection Support Officer
	Annie Bunce	Research Officer
	Becky Duffield	Research Officer
	Rosanna Ellul	Assistant NPM Coordinator
	Ruth Mostyn-Dignan	Administrative Support Officer to the Deputy Chief Inspector
	Hannah Pittaway	Policy Officer
	Charlie Pym	Inspection Support Officer
	Shannon Sahni	Research Assistant
	Kam Sarai	Inspector
	Helen Saunders	Publications and Digital Communications Officer
	Catherine Shaw	Head of Research, Development and Thematics
	Jed Waghorn	Research Trainee
	Caroline Wright	Inspector

Stakeholder feedback

We conduct an annual online survey of stakeholders to inform our corporate planning process. A link to the questionnaire is distributed to our mailing list of contacts by email and publicised via staff and professional bulletins, a link on our website and Twitter alerts. The 2021 survey which was conducted in November 2021 received 127 complete responses.

The 2021 survey included questions about the ongoing impact of the COVID-19 pandemic on our work, and on some of our activities since returning to full inspections in May 2021. Over half of respondents (57%) said they had visited the COVID-19 section of the HMI Prisons website; 87% of these respondents found the information quite or very useful and 90% agreed that we had kept stakeholders well informed about our response to the pandemic. Just over two-thirds agreed that HMI Prisons 'has continued to fulfil its statutory duty to report accurately, impartially and publicly on the treatment and condition of detainees' both during the pandemic and since reinstating a full inspection methodology in May 2021.

A high proportion of respondents (86%) had visited the HMI Prisons website in the last 12 months, the vast majority (87%) doing so once a month or less. The most common reason for visiting the website was to access an HMI Prisons report, cited by 85%. This year's survey sought stakeholders' views on the two types of reports published over the past 12 months: scrutiny visit reports and newly revised full inspection reports. There was high agreement across the 102 stakeholders who answered this question that the structure of reports was easy to follow, reports clearly explained the inspection purpose, the design made the reports easy to read, reports were sufficiently detailed, reports were useful, and reports adequately addressed equality and diversity issues for detainees (ranging from 84% to 98%).

Just under a third of survey respondents followed HMI Prisons on Twitter, and 74% reported that the tweets were either very or quite useful.

Of the 82 of respondents who told us whether they had seen any print or broadcast media about HMI Prisons in the last 12 months, 66% of respondents had seen items about HMI Prisons on national TV, 54% in national newspapers, and 87% had seen an online news story about the Inspectorate.

Communications

We issued 53 media releases in the year, a reduction from 64 in the previous year and reflecting our return from shorter scrutiny visits during the COVID-19 pandemic to full inspection reports. Our Twitter feed, which at the end of March 2021 had around 17,000 followers, grew to around 18,230 followers. Our tweet about the publication of the Criminal Justice Joint Inspection review into neurodiversity within the criminal justice system in July 2021 was seen by over 69,000 Twitter users, and a tweet about Chief Inspector Charlie Taylor's appearance on BBC Radio 4 World at One to discuss the issuing of an Urgent Notification at the 'violent and unsafe' Chelmsford prison was seen over 33,000 times. Tweets about Charlie Taylor's blog on open prisons in May 2021 and our inspection of HMP/YOI Low Newton women's prison were both viewed over 20,000 times and helped to drive readers to our website. By the end of the year our LinkedIn account had over 1,200 followers, including many professionals in the prisons sector.

Eleven

Appendices

Appendix one

Reports published 1 April 2021 to 31 March 2022

Establishment	Date published
Leyhill SV	7 April 2021
Grendon SV	13 April 2021
Peterborough (women) SV	20 April 2021
Bedford SV	21 April 2021
Exeter SV	27 April 2021
Harmondsworth IRC SV	30 April 2021
Bure SV	30 April 2021
High Down SV	13 May 2021
Ford SV	19 May 2021
Thorn Cross SV	25 May 2021
East Sutton Park SV	27 May 2021
North Sea Camp SV	2 June 2021
Parc Children's Unit SV	2 June 2021
Durham court custody	15 June 2021
Sudbury SV	17 June 2021
Oakhill STC	22 June 2021
Lithuania escort and removals	24 June 2021
Cleveland police custody suites	12 August 2021
Send	26 August 2021
Haverigg	1 September 2021
Oakwood	3 September 2021
Low Newton	7 September 2021
Wormwood Scrubs	9 September 2021

Establishment	Date published
Usk and Prescoed	1 October 2021
Rainsbrook STC	1 October 2021
Swinfen Hall	6 October 2021
Oakhill STC monitoring visit	11 October 2021
Deerbolt	12 October 2021
London South and Central court custody	15 October 2021
Spain and Portugal escorts and removals	19 October 2021
Downview	27 October 2021
Hull	2 November 2021
Dungavel IRC	11 November 2021
Belmarsh	12 November 2021
Cookham Wood	16 November 2021
Oakhill STC	19 November 2021
Chelmsford	24 November 2021
Brinsford	30 November 2021
Erlestoke	7 December 2021
Kent police custody suites	9 December 2021
Detention of migrants at Dover and Folkestone	10 December 2021
Woodhill	14 December 2021
Residential STHFs (Larne House, Manchester Airport and Yarl's Wood)	16 December 2021
Manchester	21 December 2021
Oakhill STC monitoring visit	4 January 2022

Establishment	Date published
Wandsworth	6 January 2022
Styal	12 January 2022
Rochester	1 February 2022
Surrey police custody suites	2 February 2022
Warwickshire police custody suites	2 February 2022
Foston Hall	9 February 2022
Altcourse	18 February 2022
Swaleside	22 February 2022
Thameside	1 March 2022
Durham	11 March 2022
Wetherby and Keppel Unit	16 March 2022

Appendix two

Healthy prison and establishment assessments 1 April 2021 to 31 March 2022

Establishment	Inspection type	Safety	Respect	Purposeful activity	Rehabilitation and release planning
Local prisons					
HMP Wormwood Scrubs	Unannounced	3	3	2	2
HMP Hull	Unannounced	2	2	2	2
HMP & YOI Chelmsford	Unannounced	1	2	1	2
HMP Wandsworth	Unannounced	2	2	1	2
HMP Altcourse	Unannounced	2	3	3	2
HMP Thameside	Unannounced	3	3	1	2
HMP Durham	Unannounced	3	2	2	2
HMP Belmarsh	Unannounced	2	3	1	3
Training prisons					
HMP Oakwood	Unannounced	4	4	3	2
HMP/YOI Swinfen Hall	Unannounced	2	3	2	2
HMP Erlestoke	Unannounced	2	2	2	2
HMP Woodhill	Unannounced	1	2	1	2
HMP Manchester	Unannounced	2	3	2	2
HMP & YOI Rochester	Unannounced	3	2	1	3
HMP Swaleside	Unannounced	2	2	2	1
HMP Usk	Unannounced	4	4	3	3

Establishment	Inspection type	Safety	Respect	Purposeful activity	Rehabilitation and release planning
Open prisons					
HMP Haverigg	Unannounced	4	3	3	3
HMP & YOI Prescoed	Unannounced	4	4	3	4
Women's prisons					
HMP Send	Unannounced	4	4	2	3
HMP & YOI Low Newton	Unannounced	4	4	2	3
HMP & YOI Downview	Unannounced	3	2	3	3
HMP & YOI Styal	Unannounced	3	3	3	3
HMP & YOI Foston Hall	Unannounced	1	3	2	3
Young adults					
HMP/YOI Deerbolt	Unannounced	2	3	1	3
HMYOI Brinsford	Unannounced	2	2	1	3
Children and young people					
HMYOI Cookham Wood	Unannounced	2	2	1	2
HMYOI Wetherby	Unannounced	3	3	2	2
HMYOI Keppel	Unannounced	3	3	2	2
Immigration removal centre					
Dungavel IRC	Unannounced	4	4	3	4

Appendix three

Recommendations accepted in action plans received 1 April 2021 to 31 March 2022

Note: Percentages may not add up to 100% due to rounding. A dash (-) indicates the action plan was not received before the deadline.

Establishment	Recommendations			Accepted			Partially accepted (includes recommendations accepted in principle or accepted subject to resources)			Rejected		
	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total
Local prisons												
Wormwood Scrubs	7	35	42	6	25	31	0	8	8	1	2	3
Hull	8	15	23	6	11	17	2	1	3	0	3	3
Belmarsh	7	22	29	7	19	26	0	1	1	0	2	2
Wandsworth	9	20	29	6	17	23	3	3	6	0	0	0
Altcourse	10	20	30	9	19	28	1	1	2	0	0	0
Thameside	8	15	23	7	15	22	0	0	0	1	0	1
Durham	–	–	–	–	–	–	–	–	–	–	–	–
Chelmsford	8	16	24	8	14	22	0	2	2	0	0	0
Total	**57**	**143**	**200**	**49 86%**	**120 84%**	**169 85%**	**6 11%**	**16 11%**	**22 11%**	**2 4%**	**7 5%**	**9 5%**

Establishment	Recommendations			Accepted			Partially accepted (includes recommendations accepted in principle or accepted subject to resources)			Rejected		
	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total
Category B training prisons												
Woodhill	8	20	28	7	17	24	1	2	3	0	1	1
Swaleside	13	21	34	12	19	31	1	1	2	0	1	1
Manchester	10	14	24	10	10	20	0	4	4	0	0	0
Total	**31**	**55**	**86**	**29 94%**	**46 84%**	**75 87%**	**2 6%**	**7 13%**	**9 10%**	**0 0%**	**2 4%**	**2 2%**
Category C training prisons												
Oakwood	6	18	24	4	13	17	1	3	4	1	2	3
Swinfen Hall	9	25	34	7	23	30	2	2	4	0	0	0
Erlestoke	13	19	32	10	14	24	3	5	8	0	0	0
Rochester	–	–	–	–	–	–	–	–	–	–	–	–
Prescoed/ Usk	2	18	20	2	15	17	0	1	1	0	2	2
Total	**30**	**80**	**110**	**23 77%**	**65 81%**	**88 80%**	**6 20%**	**11 14%**	**17 15%**	**1 3%**	**4 5%**	**5 5%**
Young adults												
Deerbolt	12	4	16	9	4	13	3	0	3	0	0	0
Brinsford	13	2	15	11	2	13	2	0	2	0	0	0
Total	**25**	**6**	**31**	**20 80%**	**6 100%**	**26 84%**	**5 20%**	**0 0%**	**5 16%**	**0 0%**	**0 0%**	**0 0%**

Establishment	Recommendations			Accepted			Partially accepted (includes recommendations accepted in principle or accepted subject to resources)			Rejected		
	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total
Open prisons												
Haverigg	3	17	20	2	14	16	1	3	4	0	0	0
Total	**3**	**17**	**20**	**2 67%**	**14 82%**	**16 80%**	**1 33%**	**3 18%**	**4 40%**	**0 0%**	**0 0%**	**0 0%**
Women's prisons												
Send	3	27	30	2	23	25	1	2	3	0	2	2
Low Newton	6	23	29	4	18	22	1	0	1	1	5	6
Styal	4	16	20	3	14	17	1	2	3	0	0	0
Foston Hall	15	7	22	13	5	18	2	2	4	0	0	0
Downview	5	26	31	4	24	28	1	1	2	0	1	1
Total	**33**	**99**	**132**	**26 79%**	**84 85%**	**110 83%**	**6 18%**	**7 7%**	**13 10%**	**1 3%**	**8 8%**	**9 7%**
Children and young people's establishments												
Wetherby & Keppel	–	–	–	–	–	–	–	–	–	–	–	–
Cookham Wood	14	2	16	14	2	16	0	0	0	0	0	0
Total	**14**	**2**	**16**	**14 100%**	**2 100%**	**16 100%**	**0 0%**	**0 0%**	**0 0%**	**0 0%**	**0 0%**	**0 0%**
Prison total	**193**	**402**	**595**	**163 84%**	**337 84%**	**500 84%**	**26 13%**	**44 11%**	**70 12%**	**4 2%**	**21 5%**	**25 4%**

Establishment	Recommendations			Accepted			Partially accepted (includes recommendations accepted in principle or accepted subject to resources)			Rejected		
	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total
IRCs												
Dungavel	3	14	17	2	8	10	1	1	2	0	5	5
Total	**3**	**14**	**17**	**2 67%**	**8 57%**	**10 59%**	**1 33%**	**1 7%**	**2 12%**	**0 0%**	**5 36%**	**5 29%**
STHFs												
Migrant detention facilities	6	9	15	4	4	8	2	3	5	0	2	2
Larne House	0	8	8	0	3	3	0	3	3	0	2	2
Manchester Airport	0	6	6	0	2	2	0	1	1	0	3	3
Yarl's Wood	0	8	8	0	5	5	0	0	0	0	3	3
Total	**6**	**31**	**37**	**4 67%**	**14 45%**	**18 49%**	**2 33%**	**7 23%**	**9 24%**	**0 0%**	**10 32%**	**10 27%**
Overseas escorts												
Lithuania escort	0	8	8	0	5	5	0	2	2	0	1	1
Spain and Portugal	0	6	6	0	3	3	0	1	1	0	2	2
Total	**0**	**14**	**14**	**0 0%**	**8 57%**	**8 57%**	**0 0%**	**3 21%**	**3 21%**	**0 0%**	**3 21%**	**3 21%**

Establishment	Recommendations			Accepted			Partially accepted (includes recommendations accepted in principle or accepted subject to resources)			Rejected		
	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total
Courts												
Durham courts	4	14	18	4	12	16	0	2	2	0	0	0
London South and Central courts	9	17	26	8	14	22	1	3	4	0	0	0
Total	**13**	**31**	**44**	**12 92%**	**26 84%**	**38 86%**	**1 8%**	**5 16%**	**6 14%**	**0 0%**	**0 0%**	**0 0%**

Appendix four

Recommendations achieved in inspection reports published 1 April 2021 to 31 March 2022

Note: Percentages may not add up to 100% due to rounding. A dash (-) indicates the action plan was not received before the deadline.

Establishment	Recommendations (excluding recommendations no longer relevant, housekeeping points and good practice)			Achieved			Partially achieved			Not achieved		
	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total
Local prisons												
Wormwood Scrubs	10	21	31	1	4	5	2	9	11	7	8	15
Hull	4	33	37	2	13	15	1	1	2	1	19	20
Belmarsh	5	26	31	1	12	13	2	2	4	2	12	14
Chelmsford	9	0	9	0	0	0	2	0	2	7	0	7
Wandsworth	6	48	54	1	13	14	2	8	10	3	27	30
Altcourse	3	42	45	1	21	22	1	4	5	1	17	18
Durham	5	50	55	3	18	21	1	3	4	1	29	30
Thameside	4	53	57	0	18	18	1	14	15	3	21	24
Total	**46**	**273**	**319**	**9 20%**	**99 36%**	**108 34%**	**12 26%**	**41 15%**	**53 17%**	**25 54%**	**133 49%**	**158 50%**

Establishment	Recommendations (excluding recommendations no longer relevant, housekeeping points and good practice)			Achieved			Partially achieved			Not achieved		
	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total
Category B training prisons												
Woodhill	3	46	49	0	22	22	0	6	6	3	18	21
Manchester	5	49	54	1	14	15	1	3	4	3	32	35
Swaleside	5	44	49	1	9	10	0	7	7	4	28	32
Total	**13**	**139**	**152**	**2 15%**	**45 32%**	**47 31%**	**1 8%**	**16 12%**	**17 11%**	**10 77%**	**78 59%**	**88 58%**
Category C training prisons												
Oakwood	3	25	28	1	17	18	0	0	0	2	8	10
Swinfen Hall	4	40	44	0	18	18	0	6	6	4	16	20
Erlestoke	4	55	59	0	19	19	1	9	10	3	27	30
Rochester	4	25	29	2	20	22	2	2	4	0	3	3
Prescoed/Usk	4	33	37	2	17	19	1	3	4	1	13	14
Total	**19**	**178**	**197**	**5 26%**	**91 51%**	**96 49%**	**4 21%**	**20 11%**	**24 12%**	**10 53%**	**67 38%**	**77 39%**
Young adults												
Deerbolt	2	41	43	2	20	22	0	0	0	0	21	21
Brinsford	4	38	42	2	13	15	0	2	2	2	23	25
Total	**6**	**79**	**85**	**4 67%**	**33 42%**	**37 44%**	**0 0%**	**2 3%**	**2 2%**	**2 33%**	**44 56%**	**46 54%**

Establishment	Recommendations (excluding recommendations no longer relevant, housekeeping points and good practice)			Achieved			Partially achieved			Not achieved		
	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total
Open prisons												
Haverigg	3	29	32	2	22	24	1	5	6	0	2	2
Total	**3**	**29**	**32**	**2 67%**	**22 76%**	**24 75%**	**1 33%**	**5 17%**	**6 19%**	**0 0%**	**2 7%**	**2 6%**
Women's prisons												
Send	0	16	16	0	10	10	0	2	2	0	4	4
Low Newton	3	25	28	0	11	11	0	2	2	3	12	15
Styal	1	30	31	0	12	12	1	7	8	0	11	11
Downview	3	38	41	1	18	19	1	3	4	1	17	18
Foston Hall	1	36	37	0	12	12	0	0	0	1	24	25
Total	**8**	**145**	**153**	**1 13%**	**63 43%**	**64 42%**	**2 25%**	**14 10%**	**16 10%**	**5 63%**	**68 47%**	**73 48%**
Children and young people's establishments												
Cookham Wood	11	13	24	2	5	7	0	0	0	9	8	17
Wetherby & Keppel	4	23	27	1	7	8	0	3	3	3	13	16
Total	**15**	**36**	**51**	**3 20%**	**12 33%**	**15 29%**	**0 0%**	**3 8%**	**3 6%**	**12 80%**	**21 58%**	**33 65%**
Prison total	**110**	**879**	**989**	**26 24%**	**365 42%**	**391 40%**	**20 18%**	**101 11%**	**121 12%**	**64 58%**	**413 47%**	**477 48%**

Establishment	**Recommendations** (excluding recommendations no longer relevant, housekeeping points and good practice)			**Achieved**			**Partially achieved**			**Not achieved**		
	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total
IRCs												
Dungavel	2	32	34	1	17	18	0	4	4	1	11	12
Total	**2**	**32**	**34**	**1 50%**	**17 53%**	**18 53%**	**0 0%**	**4 13%**	**4 12%**	**1 50%**	**11 34%**	**12 35%**
STHFs												
Migrant detention facilities	6	3	9	0	0	0	0	1	1	6	2	8
Larne House	0	10	10	0	4	4	0	2	2	0	4	4
Manchester Airport	0	7	7	0	2	2	0	4	4	0	1	1
Yarl's Wood	4	6	10	2	3	5	0	1	1	2	2	4
Total	**10**	**26**	**36**	**2 20%**	**9 35%**	**11 31%**	**0 0%**	**8 31%**	**8 22%**	**8 80%**	**9 35%**	**17 47%**
Overseas escorts												
Lithuania escort	0	8	8	0	1	1	0	2	2	0	5	5
Spain and Portugal	–	–	–	–	–	–	–	–	–	–	–	–
Total	**0**	**8**	**8**	**0 0%**	**1 13%**	**1 13%**	**0 0%**	**2 25%**	**2 25%**	**0 0%**	**5 63%**	**5 63%**

Establishment	**Recommendations** (excluding recommendations no longer relevant, housekeeping points and good practice)			**Achieved**			**Partially achieved**			**Not achieved**		
	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total	Main recommendations	Recommendations	Total
Courts												
Durham courts	6	28	34	1	13	14	3	8	11	2	7	9
London South and Central courts	–	–	–	–	–	–	–	–	–	–	–	–
Total	**6**	**28**	**34**	**1 17%**	**13 46%**	**14 41%**	**3 50%**	**8 29%**	**11 32%**	**2 33%**	**7 25%**	**9 26%**

Appendix five

Further resources

Analysis of prisoner survey responses for adult men's and women's prisons is available on our website: **https://www.justiceinspectorates.gov.uk/hmiprisons/**

Glossary

ACCT

Assessment, care in custody and teamwork (case management for prisoners at risk of suicide or self-harm).

ACDT

Assessment, care in detention and teamwork (case management for immigration detainees at risk of suicide or self-harm).

Adult at risk

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

Aerosol generating procedures (AGPs)

Certain medical and patient care activities that can result in the release of airborne particles (aerosols), and a risk of airborne transmission of infections that are usually only spread by droplet transmission.

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**

Category A

Prisoners on the highest category of security risk whose escape would be highly dangerous.

Category B

Prisoners for whom the highest conditions of security are not necessary but for whom escape must be made very difficult.

Category C

Prisoners who cannot be trusted in open conditions who do not have the will or resources to make a determined escape attempt.

Category D

Prisoners who can be reasonably trusted to serve their sentence in open conditions.

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.

Dublin Convention

A European Union law that determines which member state is responsible for considering an asylum claim and allows member states to transfer asylum seekers to the responsible state.

HMCTS

Her Majesty's Courts and Tribunals Service

HMICFRS

Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services

HMPPS

Her Majesty's Prison and Probation Service

IEP

Incentives and earned privileges

IRC

Immigration removal centre

Key workers

Introduced under OMiC (see below), prison officer key workers aim to have regular contact with named prisoners.

Leader

Anyone with leadership or management responsibility.

Listeners

Prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners.

MAPPA

Multi-agency public protection arrangements

NPM

National Preventive Mechanism

OASys

Offender assessment system. A framework used by both prisons and probation for assessing the likelihood of reoffending and the risk of harm to others.

Ofsted

Office for Standards in Education, Children's Services and Skills

OMiC

The offender management in custody model was introduced in 2017. In the first stage, prison officer key workers were introduced with the aim of having regular contact with named prisoners. The second phase, from 2019, has seen the introduction of core offender management and prison offender managers (POMs).

OPCAT

Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment

Parkrun

A non-profit organisation that supports more than 700 communities across the country to coordinate free volunteer-led events for walkers and runners.

PECS

Prisoner Escort and Custody Services

POM

Prison offender manager; introduced under OMiC

PPO

Prisons and Probation Ombudsman

Protected characteristics

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

Recovery plan

Recovery plans are published by HMPPS and aim to ensure consistency in decision-making by governors, by setting out the requirements that must be met for prisons to move from the most restricted regime to the least as they ease COVID-19 restrictions. See: **https://www.gov.uk/government/publications/covid-19-national-framework-for-prison-regimes-and-services**

Reverse cohort unit (RCU)

Unit where newly arrived prisoners are held in quarantine for 14 days.

ROTL

Release on temporary licence

Section 136 (of the Mental Health Act)

Enables a police officer to remove from a public place someone who they believe to be suffering from a mental disorder and in need of immediate care and control, and take them to a place of safety. In exceptional circumstances, and if they are 18 or over, the place of safety may be police custody.

Secure stairs

A framework for integrated care commissioned by NHS England and Improvement for children in secure children's homes, STCs and YOIs.

Secure video calls

A system commissioned by HMPPS that requires users to download an app to their phone or computer. Before a visit can be booked, users must upload valid ID.

Shielding

Those who have health conditions that make them vulnerable to infection are held in a shielding unit.

STC

Secure training centre

STHF

Short-term holding facility

Storybook Dads

A scheme enabling prisoners to record a story for their children.

Time out of cell

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

Urgent Notification

Where an inspection identifies significant concerns about the treatment and conditions of detainees, the Chief Inspector may issue an Urgent Notification to the Secretary of State within seven calendar days stating the reasons for concerns and identifying issues that require improvement. The Secretary of State commits to respond publicly to the concerns raised within 28 calendar days.

Virtual campus

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

YOI

Young offender institution

Website references

HM Inspectorate of Prisons reports, Expectations and inspection/scrutiny visit methodology can be found at:
www.justiceinspectorates.gov.uk/hmiprisons

HM Prison and Probation Service COVID-19 official statistics can be found at:
https:// assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_ data/file/978109/HMPPS_COVID19_Mar21_Pub_Doc.pdf

HM Prison and Probation Service safety in custody statistics can be found at:
https://www.gov.uk/government/collections/safety-in-custody-statistics

Information on the National Preventive Mechanism can be found at:
www.nationalpreventivemechanism.org.uk

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